Hospital Topics

TODAY'S HOSPITAL PRACTICES

NOVEMBER 1960

46-BED INTENSIVE CARE UNIT
PAGE 24

HOW TO RUN A MEETING
PAGE 39

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*In more than 90% of patients.

For further information see postcard opposite page 126.

HOSPITAL Topics

NOVEMBER, 1960, VOL. 38, NO. 11

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Published monthly by HOSPITAL TOPICS, INC. Publication office: 30 West Washington St., Chicago 2, Ill. Telephone DEarborn 2-5148.

Eastern Sales Office: 15 W. 44th St., New York 36, N. Y. Telephone OXford 7-5262.

Subscription rates: one year, $4.50; two years, $7.00; three years, $9.00; single copy, 65 cents. Canadian and foreign subscriptions: one year, $5.50; two years, $9.00; three years, $12.00; single copy, 75 cents. Entered as second class matter at the Post Office, Chicago, Ill. Additional entry at Barrington, Ill.

Change of address notices, undeliverable copies, and subscription orders should be sent to: HOSPITAL TOPICS, 30 West Washington St., Chicago 2, Ill.

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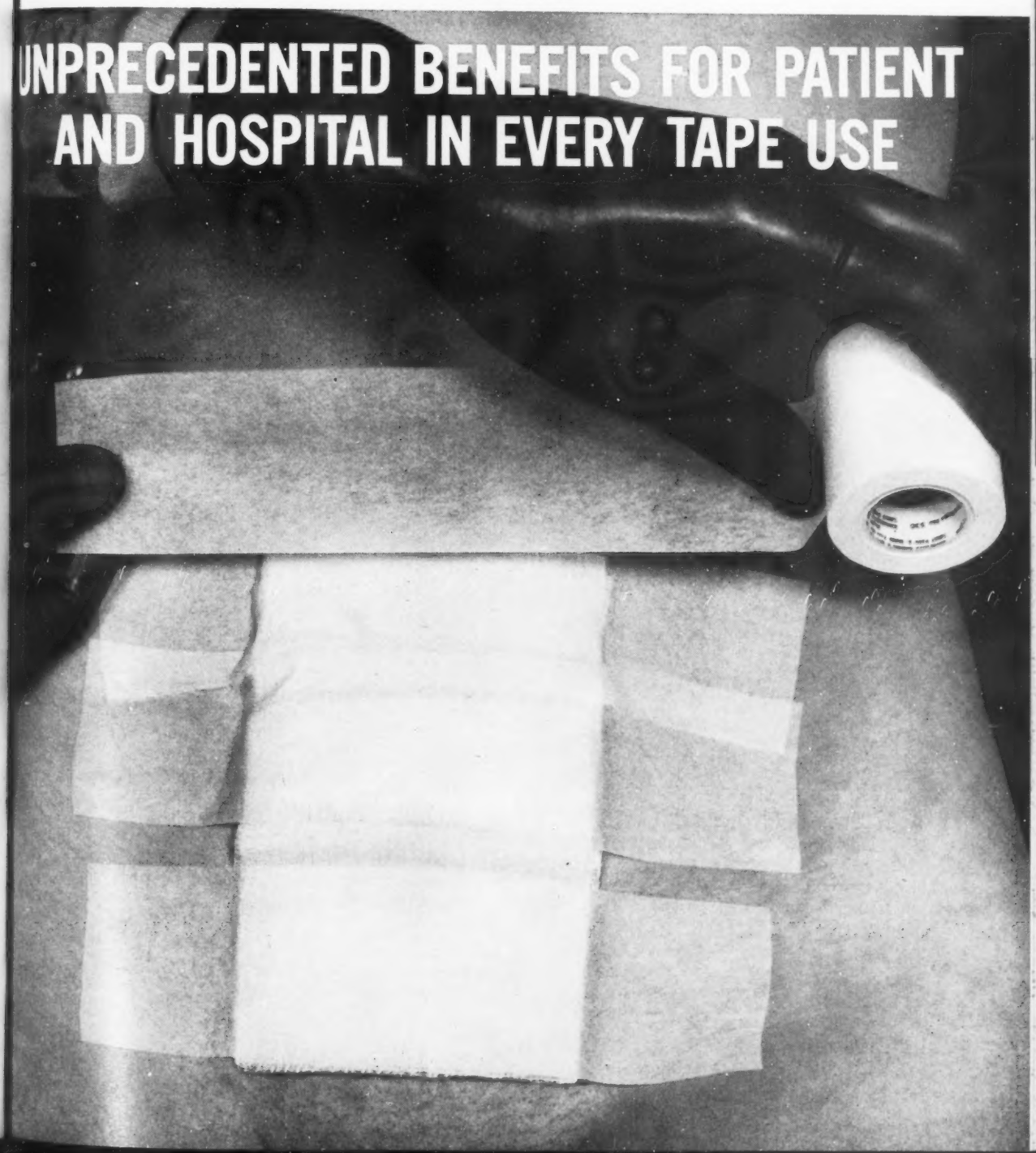

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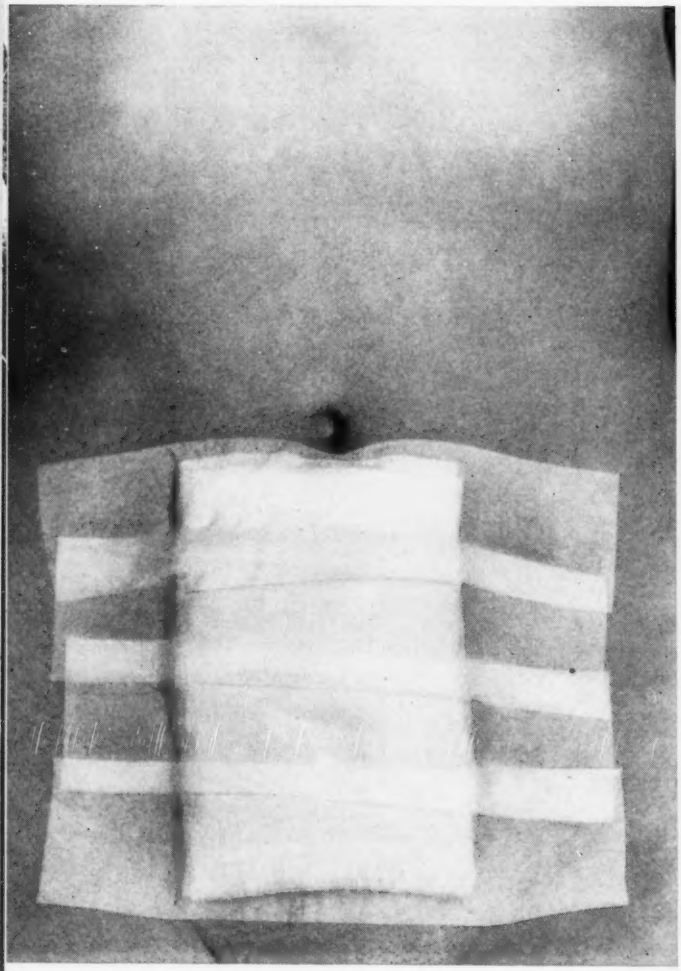

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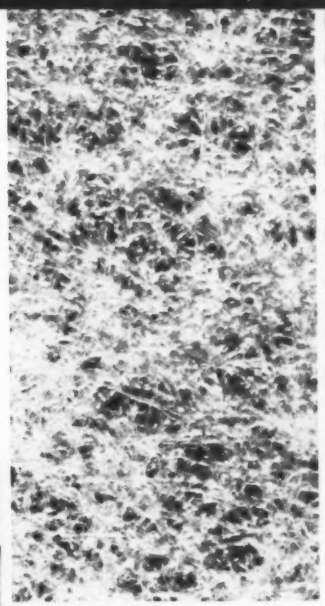

EXCLUSIVE CONSTRUCTION:

LEFT: Macrophotograph of "SCOTCH" Surgical Tape shows totally microporous structure of both the non-woven fabric backing and the thin, non-reactive, non-mobile adhesive, which permit free passage of underlying perspiration and exudates.

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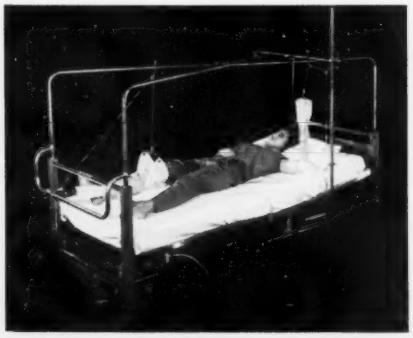

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THIS MONTH IN Hospital Topics

- TOPICS' recent articles on progressive patient care have aroused widespread attention and interest. This month our feature editor reports on another aspect of PPC: the 46-bed intensive care unit at Lower Bucks County Hospital, Bristol, Pa. (p. 24). An inside photo of some of the Bucks County people at work is the subject of our cover.

- "How to Run a Meeting" incorporates some sage advice from management consultant John G. Steinle and sociology professor Ivan Belknap on what constitutes a "successful" meeting and how it got that way. Included is a list of "do's" and "don't's". (P. 39).

- Poison control centers are becoming more and more recognized as necessary and valuable adjuncts to the life-saving process. Dr. J. R. Christian explains how they arose, their setup and organization — with stress on the pharmacist's role, present and potential. The author also sets forth a thorough listing of the supplies and equipment needed to stock a well-furnished center. (P. 59).

- "A Sick Child Is, First of All, A Child . . ." This is the title of a sensitive story on The Children's Hospital, Cincinnati. An expression of the hospital's philosophy that a child, whether sick or well, is first of all a child, not a smaller version of an adult, is reflected both in the text and accompanying pictures. (P. 63).

- A four-part form at Houston's Methodist Hospital has proved a useful device in assessing and analyzing one of the prime hospital problems today — the problem of personnel turnover. Personnel director L. R. Stom tells how the report works on p. 43.

- The milk formula room at St. Mary's Hospital, Passaic, is a part of the central service department. It's an unusual arrangement, but one that has worked out very well. Organization and responsibilities of the CS are detailed on page 87.

For cleaning all professional supplies —metal, rubber, glass, plastic —all through the hospital— use WECK CLEANER. It's wonderful!

Free Weck Cleaner is one of the Weck Specialties for the handling and processing of syringes, needles, catheters, instruments, etc., for Central Supply Service. Weck has prepared a special 8-page brochure which fully explains and illustrates this revolutionary new system. For your copy, just write to Weck.

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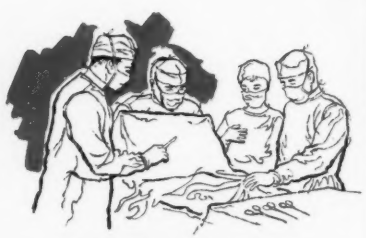
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HOSPITAL Topics
The News Magazine for the Hospital Staff

NOVEMBER, 1960
VOL. 38, NO. 11

Scanning the News

Fetal Electrocardiogram Detects Inborn Defects

An inborn defect in a baby's heart can now be diagnosed prior to birth by using an electrocardiograph. Saul D. Larks, Ph. D., and Lawrence Longo, M.D., have reported the accurate diagnoses of heart block in three infants prior to birth. They said it is now possible to obtain a highly accurate electrocardiogram as early as the twenty-second week of pregnancy.

Foreknowledge of a malformation gives adequate time to prepare for surgery immediately after delivery, if surgical intervention proves possible.

The researchers said new avenues of fruitful research may be opened by the new technic in determining precisely when congenital malformations develop. Conceivably, they added, it could be determined whether these defects are inherited or result from some infective process during pregnancy.

It's Women Doctors Three-to-One In USSR

Women doctors outnumber male physicians by about three to one in Soviet Russia, according to Col. Joe M. Blumberg, deputy director, Armed Forces Institute of Pathology.

"The ratio seems to hold from medical students on up through the specialist levels, including pathology," Col. Blumberg said.

He also pointed out that in the USSR the general practitioner has 10 years pre-college education and 6 years at a medical institute, from which he receives a diploma. He is then ready to practice at 22, the age at which many US students are entering medical school.

One of the two electronic pupillographs in existence was recently delivered to the Mayo Clinic. The instrument's prototype was developed for their laboratory by Otto Lowenstein, M.D., and Irene E. Lowenfeld, Ph.D., of the Department of Ophthalmology Laboratory of Pupillography, Columbia University, and the Institute of Ophthalmology, Presbyterian Hospital, New York City. The direct-writing electronic instrument records pupil reactions which are used to detect the presence of lesions within the nervous centers and pathways of pupillary control.

Sleepwalking Notion Debunked — Wake Them!

Sleepwalkers often fall downstairs, trip over rugs, bump into doors and suffer cuts and burns, and therefore it is absurd to assume that waking up a sleeping walker will harm him more than such accidents.

Ernest Jolowicz, M.D., New York psychiatrist, says sleepwalkers are partly awake, partly asleep, have no psychological inhibitions and can therefore exert great physiological power—sometimes propelling themselves into very dangerous situations from which they should be awakened.

He calls sleepwalking a "dream in pantomime" in which certain drives or conflicts are acted out. Best cure: remove anxiety or anxieties which cause it.

Weight-Lifting Coeds Aid Crippled Children

Twenty-four University of Wisconsin coed volunteers are participating in a weight-lifting experiment conducted by the university's new motor learning research laboratory. The students, all physical education majors, are following a grueling program of lifting heavier and heavier lead weights. Researchers are aiming at a better understanding of muscle development.

(*Continued on page* 97)

stops surgical bleeding promptly!

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Absorbable Hemostatic

OXYCEL (oxidized cellulose, Parke-Davis) produces prompt hemostasis in capillary and other small-vessel bleeding not controllable by conventional surgical methods. Applied directly from container, OXYCEL readily conforms to all wound surfaces . . . shortens operative procedures and helps to prevent postoperative hemorrhage.

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News Briefs at Press Time

ONLY 5 STATES CAN PARTICIPATE IMMEDIATELY IN AGED-CARE PROGRAM

Only five states are able to participate immediately in new federal program for medical care of aged, it was revealed at the Washington conference of state public welfare administrators in October.

The five are Arkansas, New Mexico, Michigan, Washington, and Oklahoma. Louisiana, Rhode Island, and Virginia believe they have the necessary statutory authority and are considering program drafts. Kentucky is enabled to begin participating in January.

Enabling legislation is in process in Massachusetts, New Jersey, and West Virginia, and will probably be introduced in 1961 legislative sessions in Georgia, Indiana, North Dakota, and Pennsylvania. Illinois, the District of Columbia, and Hawaii are checking their laws.

The other 32 states lack statutory authority. Furthermore, their intentions of seeking it seem doubtful at the present time.

SOCIAL SECURITY RECIPIENTS BENEFIT FROM NEW TAX LAW

Effect of outside earnings on social security benefits has been lessened under new federal tax legislation. Now social security recipient will lose $1 in benefits for each $1 earned over $1,500, but only 50 cents in benefits for each $1 earned between $1, 200 and $1,500.

Disabled workers have been made eligible for benefits, irrespective of their ages.

DRUG COUNTERFEITING ON RISE, FDA SURVEY INDICATES

Counterfeiting of prescription drugs is increasing, a nearly completed FDA survey shows.

"This reprehensible practice poses a serious threat to the public health in that it could undermine the fundamental control over the safety and efficacy of drugs," declared FDA Commissioner George P. Larrick.

G. Wayne Bye, western sales manager of Merck Sharpe & Dohme, which has been victimized by counterfeiting companies, told the Nevada State Pharmaceutical Association: "If counterfeiting continues unchecked and becomes general public knowledge, it could undermine public confidence in the integrity of the profession of pharmacy."

The counterfeiting firms, he said, have little interest in quality control, actual content of the products, or sanitary manufacturing conditions.

There are distributors pushing counterfeit merchandise "to some degree" in almost every large city in the country, according to Mr. Bye. Such distributors sell directly to retail outlets, and usually describe their wares as repackaged samples or part of a bulk purchase which they have repackaged.

Because manufacturers can prove whether tablets bearing their trademarks are of their manufacture, he pointed out, product liability for counterfeit drugs will be solely that of the druggist who knowingly or unknowingly buys and sells these products.

CHICAGO HOSPITAL COUNCIL APPROVES POLICY ON MEDICAL STAFF INTEGRATION

A policy statement opposing discrimination in appointment of medical-staff members was approved October 26 by the Chicago Hospital Council.

"The Chicago Hospital Council favors appointments of physicians who meet established professional and moral qualifications and the needs and regulations of the hospital without regard to whether the physician is Negro or white," the statement says. In its recommendations the council concurs with the Chicago Medical Society committee on hospital patient and staff integration.

Only 12 of Chicago's 65 accredited, predominantly white hospitals have Negro staff physicians, according to a recent statement by Dr. Quentin D. Young, chairman of integration committee (see HOSPITAL TOPICS, September, p. 11).

11 MAJOR FDA REFORMS SUGGESTED BY RESEARCH COUNCIL GROUP

Eleven major changes in FDA policies and procedures on control and certification of antibiotics have been proposed by a special advisory group to the National Research Council. Among revisions called for are:

Submission of proof that new drugs are effective, not merely safe; airtight record-keeping on clinical trials by manufacturers; more FDA authority on factory inspection; establishment of a permanent advisory committee of leading authorities, and appropriation of operating funds in amounts commensurate with FDA's responsibilities.

BRIEF BRIEFS

—U. S. Chamber of Commerce has appealed to business firms to investigate feasibility of conferring health-insurance benefits on retired personnel, as well as active employees—in hope that such action might help avert, or at least postpone, compulsory federal legislation for health care of the aged.

—Private expenditures for health care in 1959 totaled $18.3 billion, of which $13.2 billion was spent directly and $5.1 billion went for purchase of health insurance, according to recently published federal estimates. Thirty percent of total outlay was for hospitalization.

Gordon M. Marshall

Calendar of Meetings

NOVEMBER

2- 5 American Society of Tropical Medicine and Hygiene, Biltmore Hotel, Los Angeles

3- 4 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

4- 5 Association of Clinical Scientists, Shoreham Hotel, Washington, D.C.

4- 5 Central Society for Clinical Research, Drake Hotel, Chicago

7-11 American Association of Medical Record Librarians, Basic Institute, co-sponsored with AHA, Fontainebleau Hotel, Miami Beach, Fla.

7-11 AHA Institute, Advanced Hospital Housekeeping, Sheraton-Atlantic Hotel, New York City

7-11 AHA Institute, Hospital Purchasing, AHA Headquarters, Chicago

7-11 AHA Institute, Physical Therapists, Ambassador Hotel, Los Angeles

10-11 Kansas Hospital Association, Broadview Hotel, Wichita

10-11 Virginia Hospital Association, Hotel Roanoke, Roanoke

11-12 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, Washington, D.C.

11-18 American Occupational Therapy Association, Statler Hilton Hotel, Los Angeles

14-16 National Fire Protection Association, Deshler Hilton Hotel, Columbus, Ohio

14-17 AHA Institute, Nursing Service Supervision, Hotel Utah and Motor Lodge, Salt Lake City, Utah

14-18 American Association of Inhalation Therapists, Pick-Nicollet Hotel, Minneapolis, Minn.

16-18 Missouri Hospital Association, Hotel President, Kansas City

16-19 National Association for Mental Health, Denver-Hilton Hotel, Denver, Colo.

17-18 Minnesota Hospital Association, St. Paul Hotel, St. Paul

17-18 Arizona Hospital Association, Hiway House, Tucson

18-19 American Medical Writers' Association, Morrison Hotel, Chicago

21-22 AHA Institute, Credits and Collections, AHA Headquarters, Chicago

28-Dec. 1 American Medical Association, Clinical Meeting, Park-Sheraton Hotel, Washington, D.C.

29-Dec. 1 AHA Institute, Hospital Dental Service, Advanced, AHA Headquarters, Chicago

DECEMBER

1- 2 Florida Hospital Association, Everglades Hotel, Miami, Fla.

1- 2 Illinois Hospital Association, Pick-Congress Hotel, Chicago

1- 2 Conference on Graduate Medical Education, University of Pennsylvania Graduate School of Medicine, Philadelphia

2- 3 Regional Institute on OR Nursing, Association of Operating Room Nurses National Committee on Education, Miami Beach, Fla.

3- 8 American Academy of Dermatology and Syphilology, Palmer House, Chicago

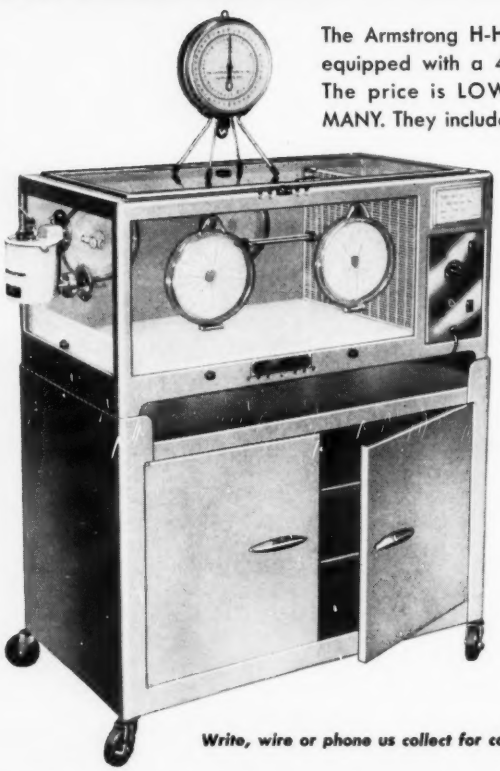
4- 9 Radiological Society of North America, Netherland-Hilton Hotel, Cincinnati, O.

5- 7 AHA Institute, Advanced Hospital Purchasing, Whitcomb Hotel, San Francisco

(Continued on page 14)

Armstrong H-H

Hand-hole type Baby Incubator



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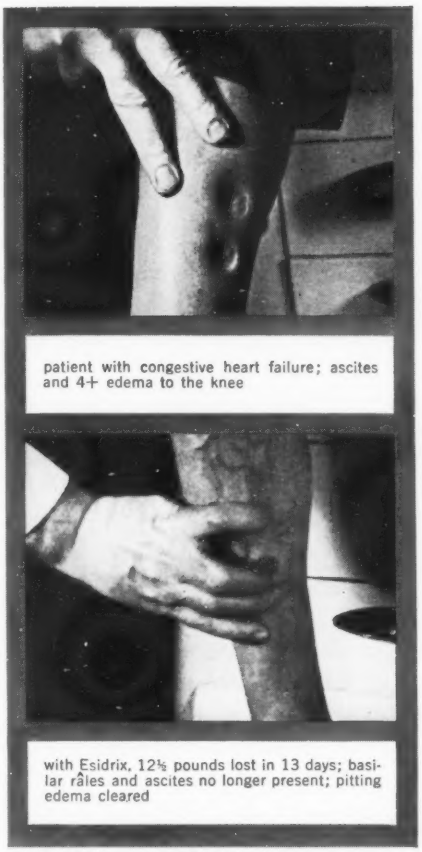

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For further information see postcard opposite page 126.

CALENDAR OF MEETINGS

(*Continued from page 12*)

5- 7 AHA Institute, Advanced, Medical Record Librarians, AHA Headquarters, Chicago

5- 8 AHA Institute, Nursing Service Supervision, Hotel Roanoke, Roanoke

8 Society of Biological Psychiatry, Hotel Roosevelt, New York City

9 American Rheumatism Association, Sheraton Dallas Hotel, Dallas, Texas

10-11 Academy of Psychoanalysis, Hotel Biltmore, New York City

12-14 AHA Institute, Labor Relations, AHA Headquarters, Chicago

12-16 AHA Institute, Hospital Design and Construction, Park-Sheraton Hotel, Washington, D.C.

26-31 American Association for the Advancement of Science, Philadelphia, Pa.

JANUARY

8 Puerto Rico Hospital Association, Medical Association Bldg., Santurce

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8-13 American Academy of Orthopaedic Surgeons, Hotel Americana, Bal Harbour, Miami Beach, Fla.

9-12 White House Conference on Aging, Washington, D.C.

16-18 American College of Surgeons, Sectional Meeting, Hotel Dinkler-Tutwiler, Birmingham, Ala.

19-20 Alabama Hospital Association, Whitley Hotel, Montgomery

23-24 National Association of Private Psychiatric Hospitals, Safari Hotel, Scottsdale, Ariz.

23-26 American College of Surgeons, Sectional Meeting, Hotels Del Prado, Reforma, Vista Hermosa, El Presidente, Alffer, Continental Hilton, Mexico City

30-Feb. 3 American Protestant Hospital Association, Muehlebach Hotel, Kansas City

30-Feb. 3 Clinical Congress of Abdominal Surgeons, Hotel Americana, Bal Harbour, Miami Beach, Fla.

FEBRUARY

1- 2 American Hospital Association, Midyear Conference of Presidents and Secretaries, AHA Headquarters, Chicago

2- 4 American College of Hospital Administrators, Fourth Annual Congress on Administration, Morrison Hotel, Chicago

4- 7 American Medical Association, Congress on Medical Education and Licensure, Palmer House, Chicago

6- 8 American Academy of Allergy, Statler-Hilton Hotel, Washington, D.C.

8-10 American Academy of Occupational Medicine, Statler Hotel, Detroit

8-11 American College of Radiology, Drake Hotel, Chicago

9-11 Society of University Surgeons, University of Kansas Medical School, Kansas City

13-15 Association of Operating Room Nurses, Civic Auditorium, San Francisco, Calif.

14-17 American Nurses' Association, Section Regional Conference, Hotel New Yorker, New York City

16-18 Central Surgical Association, Park Plaza Hotel, St. Louis

23-25 Louisiana Hospital Association, Captain Shreve Hotel, Shreveport

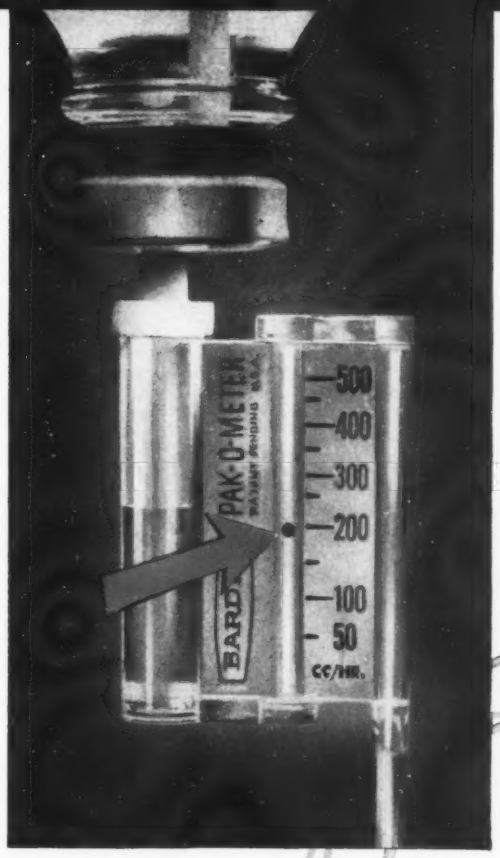
23-25 American Academy of Forensic Sciences, Drake Hotel, Chicago

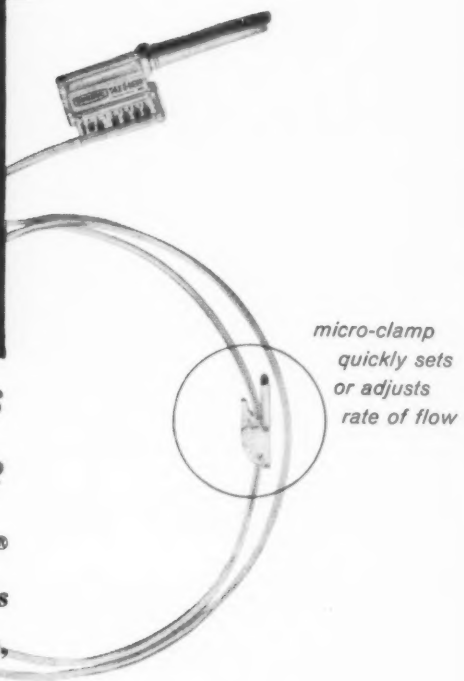
28-Mar. 3 American Nurses' Association, Sectional Meeting, Memorial Coliseum, Portland, Oregon

MARCH

5- 8 American Nurses' Association, Section Regional Conference, Hotel Denver-Hilton, Denver, Colo.

(*Continued on page 16*)





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For further information see postcard opposite page 126.

CALENDAR OF MEETINGS

(*Continued from page 14*)

6- 9 American College of Surgeons, Sectional Meeting for Surgeons and Nurses, Hotels Bellevue-Stratford, Ben Franklin, and Sylvania, Philadelphia

8-11 Neurosurgical Society of America, Boca Raton, Fla.

12-17 A...erican College of Allergists, Statler Hilton Hotel, Dallas, Tex.

13-16 National Health Council, National Health Forum, Waldorf-Astoria Hotel, New York City

15-18 American Nurses' Association, Section Regional Conference, Hotel Chase-Park Plaza, St. Louis, Mo.

16 Wisconsin Hospital Association, Schroeder Hotel, Milwaukee

20-24 American Surgical Association, Boca Raton Hotel, Boca Raton, Fla.

21-23 Kentucky Hospital Association, Phoenix Hotel, Lexington

23-24 Georgia Hospital Association, Biltmore Hotel, Atlanta

23-25 American Orthopsychiatric Association, Statler Hilton Hotel, New York City

27-29 New England Hospital Assembly, Hotel Statler, Boston

APRIL

3- 6 Ohio Hospital Association, Veterans Memorial Building, Columbus

10-12 American Academy of Pediatrics, Spring Meeting, Sheraton Park Hotel, Washington, D.C.

10-13 Southwestern Surgical Congress, St. Louis, Mo.

10-14 American Society for Experimental Pathology, Atlantic City

10-14 American Physiological Society, Atlantic City

10-14 American Society of Biological Chemists, Atlantic City

10-14 National League for Nursing, Cleveland

11-13 Industrial Medical Association, Biltmore Hotel, Los Angeles

13-14 Carolinas-Virginias Hospital Conference, Roanoke Hotel, Roanoke, Va.

13-15 American Association of Railway Surgeons, Drake Hotel, Chicago

17-20 American Academy of General Practice, Miami Beach, Fla.

19-21 Southeastern Hospital Conference, Civic Auditorium, Memphis, Tenn.

23-27 Society of American Bacteriologists, Morrison Hotel, Chicago

24-26 American Association for Thoracic Surgery, Sheraton Hotel, Philadelphia

24-27 Association of Western Hospitals, Civic Auditorium, San Francisco

21-28 American College of Obstetricians and Gynecologists, The Americana Hotel, Bal Harbour, Miami Beach, Fla.

26-28 Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo.

26-29 American College Health Association, Detroit

27-29 American Academy of Neurology, Sheraton-Cadillac Hotel, Detroit

29-30 American Psychosomatic Society, Chalfonte-Haddon Hall, Atlantic City

30 American Federation for Clinical Research, Haddon Hall, Atlantic City

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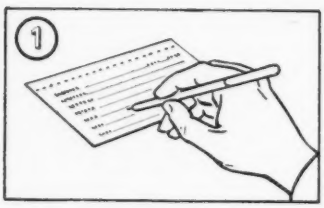

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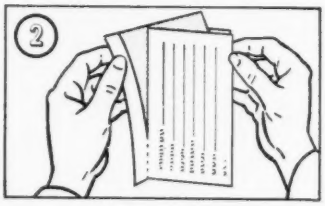

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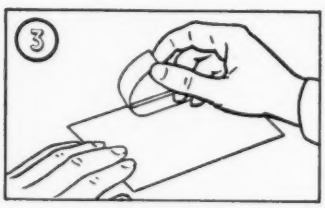

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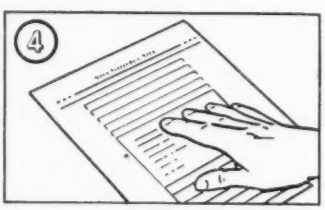

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Radiologists Stress Protection, Try New Uses of P-32

The following articles are abstracted from papers given at the 61st annual meeting of the American Roentgen Ray Society, held September 27-30 in Atlantic City, N. J. Diversity of the papers indicates the wide range of subjects of interest to the convening radiologists.

Cancer Research Fosters Swing To Treatment of Whole Person

Concern for treatment of the patient as a whole, so far as organized research is concerned, has been meager. During the past year, Congress has appropriated money for investigation of a diagnostic test in cancer. Research in this area will certainly lead to investigation of body factors that are susceptible to control by hormonal systems and other general metabolic influences. Thus, we may begin to emphasize treatment of the patient as a whole, as well as the disease from which the patient is suffering. We may learn methods by which we can influence general body systems and through them modify the neoplasm.

Anyone who has had extensive experience in the treatment of cancer is aware that there are differences in patients. Emotional stress, home environment, and other psychological factors seem to have relationship to the patient's response to various treatment methods.

I have patients who have extensive malignant disease spread throughout the body, who are living with the disease and in perfect comfort. Their disease has been controlled by radiation, surgery, hormonal therapy, and by general supportive care. In many of these cases there is a family relationship that provides a happy home. The relationship sustains the patient in his desire to get well. Under such circumstances, the good response to therapy is such that one claims a real triumph. At present, we do not know how to evaluate or measure the influence of a happy home life on the management of disease in general, and cancer in particular, but most of us certainly agree that such an environment is helpful. —*Eugene P. Pendergrass, M.D.*, Philadelphia.

Advocates More Trial of Radiation, P-32 Therapy in Breast Cancer

Radiation therapy, combined with radioactive phosphorus P-32, merits further trial in stage 2 breast cancer.

The first use of radiophosphate was based on the fact that actively dividing cancer cells require phosphorus, and on the observation that the ability of breast carcinom tissue to differentially concentrate phosphate may be as much as 10 times that of normal nonhematopoietic tissue. The hope was that mastectomy would control the lesions; that postoperative roentgenotherapy would control the disease in regional lymph nodes; and that intravenous radiophosphorus would destroy floating cancer cells and prevent distant metastases.

Definitive treatment of 94 patients studied began with a radical mastectomy not later than 10 days after the first diagnosis of breast cancer. Radiophosphorus therapy, if given as part of the definitive treatment, was begun as soon as possible after the mastectomy.

In 71 percent of the patients, the first injection of P-32 was given at the operating table at the time of the radical mastectomy, or within 24 hours thereafter.

Although the differences found in the current study are of a borderline nature, the stage 2 patients receiving P-32 and roentgenotherapy did consistently show higher survival rate than those not receiving P-32, with or without roentgenotherapy. —*Glenn F. Sheline, M.D., Malcolm D. Jones, M.D.*, and *H. Glenn Bell, M.D.*, San Francisco.

Earlier Discovery of Fetal Hydrops Possible with X-Ray

Earlier diagnosis, a result of careful x-ray studies, points to more effective management of erythroblastosis in the newborn.

Modern methods in the care of premature infants and the spectacular results of blood-replacement transfusion technics make early diagnosis of this condition of great practical importance. Traditional radiologic

(*Continued on next page*)

diagnostic signs, such as the Buddha position of the fetus with the appearance on the x-ray film of a halo around the fetal skull, have proven unreliable.

Because of the apparent unreliability of the halo sign in the experience of others as well as ourselves, and the diagnostic inadequacy of the Buddha position alone, we feel justified in extending our diagnosis by both direct and indirect roentgen signs of fetal edema. One of our patients was not suspected clinically. The roentgenologic diagnosis of fetal hydrops stimulated prompt action. Cesarean section, followed by immediate and repeated transfusions, resulted in a vigorous baby who continues to thrive.

High-speed films and intensifying screens are used in an effort to reduce the radiation dose to both mother and child. Roentgen studies are indicated whenever there is a clinical suspicion of hydramnios, and in all pregnant women who are known to be Rh-negative or who have previously had an erythroblastotic child. —*Paul A. Bishop, M.D.,* Philadelphia.

New Technic Improves Efficacy Of Intestinal Radiography

There have been few really basic advances in the radiologic study of the gastrointestinal tract since the early days of x-ray, when opaque materials were first introduced in experimental animals and x-ray films were then made of the interior structure outlined by that ingested material.

Although refinements of basic methods have been made, all deductions as to the existence of an abnormality in the gastrointestinal tract roentgenographically are still dependent upon the detection of the lesion's effect on the lumen. Although dependable for demonstrating the shape and contour of the inner surface of the bowel, existing intestinal radiography fails to provide means of assessing the architecture and limits of the whole lesion.

Consequently, roentgenologic inferences as to the specific cellular characteristics of a given lesion of the intestine can be little more than an intelligent guess based largely upon frequencies.

In our study in mesenteric arteriography, we used a film cassette wrapped in sterile plastic, placing it directly under the patient's bowel, after surgical opening of the abdomen. The roentgenograms were made before and during the terminal period of the injection of contrast material into the proper artery through a plastic catheter or needle.

Final conclusions cannot be drawn on the basis of studies done to date. Much more work will be needed before definite vascular patterns for various types of neoplasus of the stomach, small bowel, and colon are established and before validity of diagnostic criteria of this method survives repeated testing. —*Alexander R. Margulis, M.D.,* and *Peter Reinbecker, M.D.,* St. Louis.

Routine Admission X-Rays Recommended; Screening Needed

Routine chest x-ray films for adults entering a hospital are recommended provided careful protection rules are followed. Depending on local conditions, an average general-hospital admission x-ray survey program will detect approximately 3.5 cases of active tuberculosis per thousand patients examined; 4.59 patients with suspected tuberculosis; and 110 patients with significant non-tuberculosis chest abnormalities.

A routine admission survey program is of utmost importance to decrease danger of exposure of hospital personnel and patients to active tuberculosis; to facilitate adequate patient care, particularly in the early detection of silent lesions; and as an important record for future evaluation.

One exception should be made in the program. Experience in pediatric hospitals indicates that the diagnostic yield of survey films in children is so low that prudence indicates the use of the tuberculin skin test as the primary means of detecting early tuberculosis. A standard x-ray examination is recommended if the child's skin test is positive.

Where economic factors are not of primary consideration, the conventional 14" x 17" x-ray film, using optimum kilovoltage, adequate coning of the primary beam, and normal filtration, offers the least patient exposure and is therefore recommended. If the only unit available is one using photofluorographic, or miniature x-ray film, such as that used by tuberculosis association wagons, then the safest possible equipment is necessary. Such a unit should be used only for adult males and older women, and not expectant mothers.—*George T. Wohl, M.D., George Henry, M.D.,* and *Jay Wenger, M.D.,* Philadelphia.

(The following abstract is taken from a paper delivered at the 1960 AMA meeting, held recently at Miami Beach.)

New Radioactive Method Safe, Simpler In Measuring Cardiac Blood Flow

A new radioactive method makes it a safe and simple procedure for a physician to measure the quantity of blood passing through the heart muscle.

The method was developed over the last two years as part of a program for testing the effectiveness of various types of drugs used in treating coronary diseases.

We found that after administering a nitrate, such as nitroglycerin and peritrate, it was possible to monitor the radioactivity of the drug within the heart by placing a scintillation detector on the patient's chest.

By a mathematical formula, using the time it takes for this activity to affect the right and left sides of the heart and the heart muscle, one can determine the coronary blood flow and the amount of blood pumped through the heart.

We find the method much more satisfactory than catheterization which requires the passage of tubes into the heart and is technically difficult and hazardous, especially in abnormal hearts.

We have begun a study to determine whether the method can be used to predict a predisposition to heart attacks. — *Philip C. Johnson, M.D.,* and *Gunnar Sevelius, M.D.,* VA Hospital, Oklahoma City, Okla.

from AHA panelists:

• Determining Your Nursing Staff Needs

How can a hospital determine how many nurses it needs? At a panel discussion on "The Staffing Dilemma in Nursing Service" during the AHA convention in San Francisco, speakers questioned some of the often-used formulas and speculated whether overstaffing might not be more common than understaffing. Here are the highlights of their talks.

Making Nurses Budget-Conscious Results in Reduced Nursing Costs

The hospital administrator must, in conference with nursing service, assume the responsibility of forecasting and budgeting for nursing needs.

Nurses, like physicians, have markedly little exposure to hospital economics throughout their professional training. This lack of economic understanding constantly manifests itself and adds appreciably to patient costs.

We established personnel and operating budgets at our hospital on January 1, 1960, after seven years of careful cost acounting which enabled us to detail the costs of rendering hospital service.

For the first six months of 1960, the 31,611 inpatient days remained within two-tenths of one percent of being the same as the days of care rendered during the first six months of 1959; the outpatient volume (14,061 visits) increased 12 percent. The nursing staff in June, 1960, consisted of 236 persons—138 R.N.'s and 98 nonprofessional workers—compared with 235 persons in June, 1959—134 R.N.'s and 101 nonprofessional workers.

Yet, nursing-service costs for the first six months of 1960 were $10,000 below the same period for 1959 — a reduction of four percent.

I attribute the improvement to head-nurse cost consciousness created through the establishment of operating budgets and monthly performance reports.

There has been a noticeable change in attitude which is most satisfying. For years our hospital has used part-time personnel to augment the full-time nursing staff. These part-time personnel reported for duty, high census or low. Now, with one eye on the budget, head nurses on low-occupancy days ask the nursing office to place their part-time employees with some other unit that may be short-handed, or, if this can't be done, they call the part-time workers to tell them not to come in.

Application of the budget system is uncovering some interesting things about the weakness of our present formula for determining the number of personnel needed. We are learning that such formulas as the one developed by a joint committee of the AHA and NLN are not friendly to effective budgeting. How can you effectively cover a two-week vacation gap in the schedule by having someone else work 13 minutes a day throughout the year to compensate for the 10-day absence? The same is true of holidays and days off for sick leave. So what happens? We slightly overstaff throughout the year; vacations hit, and the cry goes up from the nursing division for additional help to maintain quality nursing care. The budget, or at least budget adherence, promptly goes out the window.

Obviously there are better ways to determine personnel needed for adequate staffing. I know of one 400-bed hospital that brought in a firm of management consultants who applied efficiency measurement methods and came up with staffing requirements and working schedules. As a result, there was a reduction of 20 working positions in nursing service and 42 positions in non-nursing departments. — *Kenneth E. Knapp*, administrator, Thomas D. Dee Memorial Hospital, Ogden, Utah.

Long-Range Planning Needed; Each Hospital Must Study Its Problems

Creative thinking, cooperative planning, and constant assessment of both needs and resources will do much to solve our staffing dilemma. Hospitals often do long-term planning for future building, but seldom do long-term planning for personnel. We wait until we are in an emergency situation and then scream "wolf." This chronic emergency plea is overworked.

In our own nursing department, we spent nearly

(*Continued on next page*)

six months evolving a 10-year plan. This meant considering our hospital, kind of patients, kind of medical practice, type of community, special recruitment problems, and special educational needs – and setting some long-term goals.

One important administrative decision is what level of nursing care is to be given within the hospital, including how much nursing care can be delegated to non-nurses.

There should be clearly defined job descriptions for all employees. Then, if nursing is still expected to carry housekeeping, dietary, laundry, and even medical functions, additional personnel should be provided so that these functions can be performed without diluting the nursing care which is desired by the institution.

Each hospital must make its own decisions. Other staffing patterns may be used as guides, but they are never the whole answer. Nursing-hour ratios have significance only when: (1) the categories of workers to be included are clearly defined; (2) duties to be done are clearly delineated; (3) due consideration is given to the relative value of each type of worker; (4) the value of the student and/or trainee is determined, and (5) the value of the service rendered by visitors is determined.

One of the best methods for defining patient-care needs and goals is through patient-care committees, established on each service or area, and with administrative support. When the nursing department is aware of the total care plan, then it can decide what can be eliminated or where short cuts can be made during "shortage periods."

In most hospitals of any size it is possible to predict minimum and maximum occupancy dates, based on the figures for the last several years. If this is done, the staffing patterns, including vacation schedules, can be adjusted to meet these periods of fluctuating census. An intelligent plan can be developed for vacations, so that the staff is not depleted during peak times. As many part-time people as possible should be used – people who can be called in when special problems exist.

If overstaffing occurs – and I think this is far more common than understaffing – and adjustments cannot be made, then intensive inservice programs can be carried out during this period to further enhance the value of the worker. For example, use and care of special equipment can be reviewed and its use practiced. Licensed practical nurses can be given additional special training as scrub nurses for the operating room and delivery room, or as inhalation therapists, so that they will be available when needed.

An internal study of the nursing staff can be done to determine the probable stability of the staff, the potential for higher education, the reasons why these people are working in this particular hospital (such as salary, fringe benefits, work satisfaction, reputation), and the reasons why people leave (work load, poor scheduling, poor communications, locality).

This information can be used to build the staff. One may find that the problem is entirely different from that of a neighboring hospital–and entirely different, also, from the "problem" which had been delineated 20 years ago, and parroted ever since. –*Evelyn M. Hamil, R.N.*, director, nursing services and education, Los Angeles County General Hospital.

Work Sampling Used to Determine Standards for Various Census Levels

Two years ago our hospital had the serious problem of lacking a planned level of nursing care. Nursing costs were higher than those of other hospitals in the same area and city; there were innumerable inconsistencies in staffing.

Apparently there was a significant waste of nursing personnel; nursing administration was not convinced that the number on the staff were needed for good care–but was also uncertain that some requests for more personnel were unjustifiable. Although there was pride in the quality of care, the same persons holding this view expressed concern with the adequacy of care.

Moreover, our general operation was troubled with wild fluctuations in census, inadequate facilities, and severe financial problems.

To determine the nursing-staff needs for our hospital, we decided to apply the technic of work sampling. Work sampling is a recognition of reality. To compromise with reality is not to be defeated; to do a better job tomorrow you must do the finest job you can with what is available today.

Here are our results: (1) development of seven specific staffing standards for various census levels; (2) staffing standards which are justifiable from intensive study of our operation; (3) ability to determine the monetary value of student services, because standards were based only on utilization of paid personnel; (4) elimination of fluctuating illogical concern with the adequacy of staffing; (5) ability to plan utilization of personnel;

(6) Savings of $70,000 in the first full year of operation, through elimination of inconsistencies in staffing and of intermittent overstaffing, the significant part of which was part-time personnel; (7) provision of structural framework for continuous specific adjustment because of changes in census, service and function, physical facilities, availability of personnel, concepts in use of personnel, methods, skills, work pace, standards, or economic conditions.

Although there have been many changes in the last 18 months, we are still considering standards developed from our work-sampling program as a valid reference. Changes have been carefully made in relationship with specific changes which influence staffing.

We are looking forward next year to another work-sampling program. Then, before too many changes challenge the validity of our revised staffing standards, we hope to have effective programs of method improvements, performance standard, training, reassignments of responsibility, and qualitative analysis of the services rendered to our patients.–*James H. Moss*, director, Riverside Hospital, Toledo, O.

Consultant's Corner

By John G. Steinle

[Due to continuing interest in the subject discussed below, Mr. Steinle has revised and up-dated his column in the May 1957 issue of HOSPITAL TOPICS *which effectively dealt with this problem.]*

Q. What formula do you recommend in determining hospital bed need?

A. There are several technics used to estimate the number of acute general hospital beds required for a known population. Some of the most widely used technics (and they are usually the most valid) are described in the following paragraphs.

Hospital Survey Planning And Construction Act Formula

The federal statute commonly known as the Hill-Burton Act provides for the distribution within states of 4.5 hospital beds per 1,000 population. The distribution formula consists of the assignment of 2.5 beds per 1,000 population to rural areas, 4.0 beds per 1,000 for intermediate areas, and 4.5 beds per 1,000 for base areas. Base areas are urban centers.

The difference between the assignment to rural areas and base areas is allocated to a state pool, as is the difference between the assignment to intermediate areas and base areas. The beds allocated to the state pool, in turn, are distributed among communities which have an unusual or unique need.

This distribution formula is based on the assumption that about 45 percent of the hospital needs of rural communities are provided by surrounding communities of either intermediate or base size, and that approximately 10 percent of the hospital needs of the communities of intermediate size will be met by base-size communities.

Bed-Death Ratio

A close relationship has been established between the number of deaths occurring in hospitals and the total number of patient-days of hospital care required by a community. Studies of this relationship have led to the development of a formula for estimating hospital bed needs based on vital statistics. A detailed explanation of this technic is included in the report of the Commission on Hospital Care published in 1947 by the Commonwealth Fund under the title, "Hospital Care in the United States."

This technic applies a ratio of beds to annual deaths in the area. For example, if the arbitrary ratio is 0.5 general beds per annual death, the formula may be applied to either the mortality rate or to the total deaths occurring in the area. If, in a community of 20,000 people, an annual death rate of 10 per 1,000 population is assumed, then 0.5 times 10 equals five beds per each 1,000 population, or 100 beds in all. By the other method, if there are 200 deaths annually in the community, 0.5 times 200 indicates a need for 100 hospital beds.

In the development of this technic by the Commission on Hospital Care, it was specified that 50 percent of the deaths could be expected to occur in hospitals. Experience has shown, however, that this factor varies considerably in different parts of the country and even in various sections of the same state or county.

Analysis Of Age Composition

Studies have developed the fact that the age distribution in the community population is the dominant factor in the amount of hospitalization needed. The bed need appears to be in direct ratio to the age composition of the community. The larger the number of persons in the higher age groups, the greater the need for hospital beds.

Studies over a period of some seven years in a number of communities have led to the development of detailed criteria for annual hospital bed-days required by service for each age group of the population. Standards, or factors, were first developed regarding the annual bed-days per person required by each age group. These were further refined to give the annual hospital-day requirements by type of service, i.e., medicine, surgery, obstetrics and pediatrics, within each age group and by sex.

For estimating hospital bed requirements, I strongly favor the age composition formula. We have applied this technic to a number of areas, apparently with good success. The method is more precise than the

(Continued on page 72)

46-Bed Intensive Care Unit Largest in the United States, Distinctive in Concept, Procedure

by

Ellen L. Davis

The stimulant box, one of the emergency aids kept handy in the intensive care unit, is checked by Elaine Rucker, R.N. Complete, specialized equipment is, of course, standard in the unit. Unlike most units of its kind, the one at Lower Bucks County Hospital does not admit children. Instead, complete duplicate equipment is kept in the self-sufficient pediatric unit in order to keep the seriously ill child in his own special environment.

When one is tackling a big job, thinking big can accomplish some remarkable giant steps not normally considered par for the physical stature of the individual, or the institution. Lower Bucks County Hospital, in Bristol, Pa., with 222 beds and 57 bassinets, classifies as a medium-sized hospital. Yet its over-all accomplishments, and especially its record in several departments, would do credit to a metropolitan center with much larger facilities and resources.

In obstetrics, its birth rate ranks it in the 'Big Ten' in Pennsylvania, not only in its own service area, but in competition with much larger hospitals in Philadelphia. (*For the complete story of the hospital's maternity wing, see the Pediatrics-OB section of last month's issue of* Topics, *beginning on page 93.*)

In the field of progressive patient care, its 46-bed intensive-care unit is, to the best knowledge of the hospital and the editors of Topics, the largest operated by any community hospital in the United States.

When plans for the erection of the new hospital were set in motion seven years ago, those charged with the responsibility of its planning evaluated the financial and personnel potential, together with other familiar hard facts of such an undertaking, and decided on a 50-bed hospital. Then they evaluated the service area, in the heart of the booming Delaware Valley

Mary T. Ancker, administrator of Lower Bucks County Hospital since 1956, was also chairman of the original fund drive for the hospital in 1953.

industrial center, took a deep breath, gave a mighty upward thrust to their collective mental horizons, and authorized architectural plans for a 150-bed hospital.

One of those thinking big at the time was Mary T. Ancker, who in August, 1953, was named chairman of the fund drive for the hospital. When it opened in November of 1954, she was appointed director of community relations. Four months later she was named assistant administrator, and in January, 1956, she became administrator.

Mrs. Ancker received her R. N. diploma from Conemaugh Valley Memorial Hospital in Johnstown, Pa., took special courses in pediatrics, psychology and administration at the University of Pennsylvania, and did postgraduate work at Children's Hospital in Philadelphia. One of the comparatively few women administrators in Pennsylvania, she is also one of the busiest. She is on the board of directors of the Keene Home for the Aged in Bristol, served on the joint consultative board for the aged of the Episcopal Diocese of Pennsylvania, and received a special award from President Dwight D. Eisenhower for her work in organizing the blood program in Lower Bucks County.

"We have to think big," said Mrs. Ancker, "because we have a big job to do. The population of Lower Bucks County has increased 300 percent since 1951, and is still going up. Our service area now covers a population of over a quarter of a million, and our occupancy has topped 100 percent almost consistently since we first opened. *But*, we must also keep our thinking, and our functioning, simple. To confuse 'big' with 'complex' would almost inevitably result in chaos. Our high level of occupancy is accepted, and handled, as the norm. To operate mentally and physically as though this norm were an emergency, temporary, status would result in frustration for our staff and irritation for our patients.

"When a youngster bumps into something and takes a tumble, some grownup is bound to remind him to 'Please look where you're going.' We try to look where we're going," continued Mrs. Ancker. "When we opened our 41-bed intensive-care unit in February, 1958, it was the fruition of planning started in September of 1957.

"We knew then that we were thinking big—and that we were also thinking 'different' than many hospitals with similar units. For one thing, the hospital rules governing admissions state that 'All patients requiring intensive care as determined by the nursing-care requirements will be admitted to the intensive-care unit, *regardless of the doctor's request.*'

"For another, we reverse the usual ratio of surgical and medical patients; the majority of our patients are hospitalized for medical reasons. For still another, there is no extra charge for special care, and no bonus or extra pay has been given to the nursing personnel in the department."

The five months of concentrated planning included meetings of the administrator with the nursing director and medical-surgical supervisor, the medical staff and the admissions office. This was followed by individual conferences with doctors and the nursing staff, in order to get everyone's cooperation and prevent objections or misconceptions regarding the plan.

With the staff fully informed, the hospital went about informing the public. Press releases were sent to local and Philadelphia papers; radio and TV stations in Philadelphia were utilized, and one station in Doylestown, Pa., and two in Trenton, N. J., picked up and repeated newscasts regarding the unit.

The public was told that under the plan, patients requiring continuous treatment, skilled nursing, close observation, or whose activities must be rigidly controlled, would be placed in the intensive-care unit, where special equipment, necessary drugs, and personnel would be concentrated; that the nursing staff would be increased on all shifts, and visiting hours kept to a minimum.

"Thus the public was well informed, and well disposed towards the unit when it opened. We did temporarily lose our local florists," smiled Mrs. Ancker, "when the erroneous report was circulated that patients in the area would not be permitted to receive flowers. What we do request is that the families take the flowers and plants home and care for them until such time as the patient is well enough to enjoy them in the moderate care unit. With this straightened out, the florists are with us again, even to the point of recommending more lasting floral arrangements.

"Since the very beginning," continued Mrs. Ancker, "the responsibilities of every single individual who works in the hospital has been spelled out, and adhered to, down to the last and least detail. The contribution to the team of every professional and nonprofessional worker is stated with clarity and authority, yet with such simplicity that it becomes a fundamental part of the person."

The atmosphere created by this philosophy, as observed by TOPICS' reporter, is one of relaxed alertness. The confidence, the sense of knowing-where-it's-going that permeates the staff, is reflected in the patients.

The proof of the pudding, according to Evelyn

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Buck, supervisor of all medical-surgical areas, is that "when a $700,000 building program enlarged our facilities to 222 beds and gave us an entirely new, $200,000 46-bed intensive care unit in December of 1959, we put in several innovations in hospital construction based on our experience in intensive care during the previous year. But we did not introduce any innovations in the way the unit operates, nor any change in viewpoint about our objectives and how to best achieve them."

For the first 11 months of the intensive-care unit operation, the death rate was 10 percent—an encouragingly low figure considering the high census and the number of terminal cases in the unit. Although the hospital does not usually take those long-term cases which can go to a nursing home, it does take patients who require hospitalization, regardless of the critical or terminal nature of their illness.

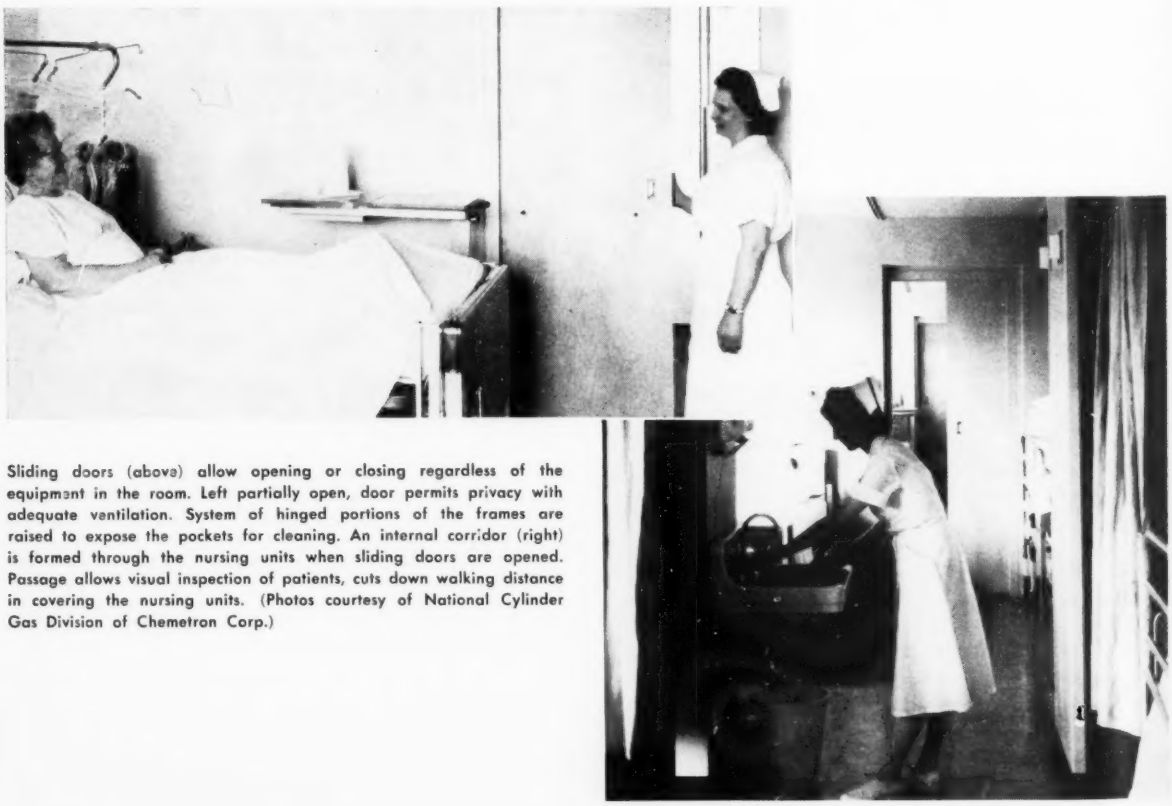
The types of cases treated in the intensive-care wing are, in the order of frequency, coronaries, G. I. bleeders, diabetics, vertebral fractures, C.V.A., subtotal gastrectomies, cholecystectomies, craniotomies, limb amputations, laminectomies, suprapubic prostatectomies, and extensive burns.

"Though our close proximity to the state toll road brings in many victims of traffic accidents," said Miss Buck, "and the fact that we serve a highly industrialized area accounts for many other types of accidents, the majority of our intensive-care patients are in the older age category. Coronaries, of course, make up our number one category, and the doctors like these patients to remain in the unit at least six weeks. We find that when they are taken off the unit and given a phone and more visitors, in a unit where fewer nurses are available, they try to do too much for themselves, with regressive results. Not only do these patients need longer intensive care, but also many of them are in the age bracket where they are most vulnerable economically. The fact that there is no extra charge for intensive care means they get the ultimate in nursing care for the minimum expenditure.

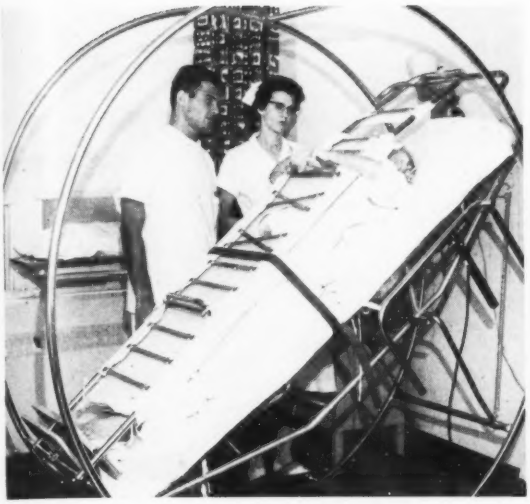
"It has been our policy from the start to place patients primarily by medical nursing needs," emphasized Mrs. Ancker. "Probably most hospitals have this objective theoretically, but we give a great deal of consideration to the psychological as well as the physical needs of the patient.

"It is my deep-rooted conviction that a child in a bed next to a seriously ill adult is not in a healtful psychological environment. Therefore, no children are admitted to the intensive-care unit. Pediatrics is self-sufficient, with all the emergency equipment right on the floor, including portable oxygen, Croupettes and suction apparatus. Trays are set up, ready for any emergency. All equipment used for adults in intensive care is also on hand in the pediatrics unit.

"Just as children do not adjust well to adult surroundings, not all adults adjust well to too many of their own kind! Patients are paying for semi-private accommodations, and their insurance states they are covered for such accommodations. But in some hospitals they may find themselves in a room with six or



Sliding doors (above) allow opening or closing regardless of the equipment in the room. Left partially open, door permits privacy with adequate ventilation. System of hinged portions of the frames are raised to expose the pockets for cleaning. An internal corridor (right) is formed through the nursing units when sliding doors are opened. Passage allows visual inspection of patients, cuts down walking distance in covering the nursing units. (Photos courtesy of National Cylinder Gas Division of Chemetron Corp.)



Beverly Vandenberg, R.N., adjusts the Stryker Circ-O-Lectric bed while Stephen De Felice, M.D., intern, reassures the elderly patient to whom the positioning is new and strange.

On the road to convalescence, and contentedly at ease, the patient now finds the bed a wonderful hospital companion. "We adjusted to each other just fine," she said.

eight other patients, because that is all that is available at the time."

"Though we run a consistently high census," added Miss Buck, "we always try to keep a few beds for emergencies. And just as we take a broad view of the type of patients who require intensive nursing care, we take a strict view of the type of patient who does *not* need it."

The 46-bed unit constitutes 34.3 percent of all medical-surgical beds in the hospital. Of the total number of admissions, 20.7 percent of the patients go to the intensive-care wing, which in its first year of operation cared for 1,500 patients.

A three-month survey of the diagnoses and average length of stay on the unit showed that congestive heart failure accounted for the largest number of admissions as well as the longest average stay—48 days. The average stay for multiple fractures and gunshot wounds was 38 days; for pancreatitis, 37 days; and for herniated disc, 33 days. Single admissions with a much longer-than-average stay—such as one patient with ulceration of the leg and complications, who remained in intensive care for 154 days—are not included in the general figures.

The rate of occupancy for the fiscal year of 1959 for the entire hospital was 106.9 percent. For nearly six months, of course, the capacity was 150 beds. In the last few months of the fiscal year, with a 48 percent increase in capacity, the rate of occupancy has approached the 100 percent figure, with over 1,000 admissions per month. Currently, the rate is running well over the previous rate of 12,000 admissions per year.

Patients requiring intensive care are admitted directly to the area, or by transfer from other areas or the recovery room if their condition warrants it by virtue of diagnosis. All patients who have had major surgery are admitted directly from the recovery room. A simple appendectomy, of course, would not be admitted, since postoperatively he would go from the recovery room to the moderate care area.

Once the patient is able to help himself, he is transferred, regardless of diagnosis, to one of the other wings reserved for patients admitted for minor medical care or minor operative procedures, and convalescent transferrals from the intensive-care unit. A committee made up of representatives of the medical staff and the nursing and administrative staffs determines the admission or transfer to the intensive-care unit.

It is the head nurse who evaluates the nursing needs, with the approval of the doctor, and effects the transfer to another wing.

The reasons for the transfer are explained to the patient, and the usual reaction is, "It was wonderful when I needed it, but I'll be glad to be with people who aren't so sick." The patient is taken by wheel chair to the new bed by a nurse, never an attendant, who also takes along his chart and other pertinent information.

The nursing clerk or messenger in intensive care sends the Addressograph plate to the admissions office with a notation of the new bed assignment. Admissions makes a new plate, and puts a note in the doctor's mailbox indicating the patient's new location.

Nearly six hours of nursing care per patient is provided in the intensive-care unit, compared with approximately two hours in other units. The nursing staff comprises a total of 25 members on three shifts. This staff includes 12 registered nurses and 13 subprofessionals, in addition to one supervisor and a day-shift nursing clerk.

Nurses work in two teams per shift, each covering a section of the floor. One medication nurse is responsible for administering all medications. Each team is composed of at least one professional nurse and one

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The intravenous team working with Stephen De Felice, M.D., are, l. to r., Mary Lou Davies, R.N.; Theodora Schneider, R.N.; and Ruby Wakaye Hara, R.N. Nursing in the intensive care unit offers no extra earnings or bonuses other than the reward of giving the best professional care.

or more subprofessional workers. An adequate number of permanent general nursing-staff members is assigned on a weekly basis, so that there is a minimum need for supplementing the daily staff with relief personnel. As a result there is a minimum adjustment of patients to personnel, and an incentive exists to improve nursing care quality.

Specific instructions covering various phases of intensive care are given below.

Admission of patients to intensive-care unit:

1. Prepare unit completely for type of patient being admitted.
2. Visit by team-leader on arrival to evaluate type of patient and type of care needed.
3. Orient patient and family regarding policies of hospital.
4. Notify resident of admission. It will be his duty to notify staff physician.
5. Send all belongings and valuables home with relatives.
6. Secure signature of person taking belongings home.
7. Take all valuables to cashier's desk and put in safe if no relative accompanies patient. After 4 p.m. lock in valuable drawer in narcotic area. Use valuable envelopes and mark with name of patient and contents.
8. Check valuable drawer every morning and take to cashier to be put in safe.

Duties of the head nurse

1. Delegates responsibility for patient care to assistant head nurse or team leader.
2. Plans time and work sheets.
3. Present at reading of reports.
4. Supervises over-all area.
5. Makes rounds with doctors.
6. Checks equipment.
7. Supervises ordering of supplies.
8. Evaluates personnel and makes changes as needed. Writes evaluation records of personnel.
9. Assists team leader in planning and assignments.
10. Makes contact with team members through team leader.
11. Keeps close contact with social-service director.
12. Stresses value of communications through team leader to all personnel.
13. Assigns auxiliary aids.
14. Instructs new members of team or private-duty nurses in hospital policies.
15. Meets with supervisors and department heads when problems arise.

Functions of team leader

1. Checks narcotics with on-coming nurse.
2. Receives report from off-going shift.
3. Visits each patient previous to assignment.
4. Assigns personnel as required.
5. Reviews Kardex orders against charts and checks medicine and treatment cards.
6. Pours and administers medicines.
7. Transposes orders from chart to Kardex, makes out medicine cards, etc.
8. Orders required equipment from C.S.R.
9. Checks all patients going to O.R. and on return from O.R.
10. Makes rounds with doctors when possible.
11. Visits all new admissions and delegates personnel as required.
12. Stresses value of communications through team leader to head nurse.
13. Assists head nurse in carrying out policies of hospital.
14. Relieves head nurse on her days off.
15. Supervises nursing care rendered by team.

The physical innovations incorporated in the new intensive-care wing, mentioned earlier in this article, constitute several "firsts" in hospital construction.

Aisles, going through the center of the patient rooms, in addition to the regular corridor, allow any room to be cut off by closing the completely fireproof sliding doors when privacy is desired. These extra aisles not only allow better visual supervision of patients, but save many steps for nurses, who can get more quickly from bed to bed without the necessity of going out into the main corridor.

Sliding doors, also fireproof, are employed between the rooms and the regular outside corridor. These save space, and are unhampered by equipment within the room. The doors do not have to be removed for cleaning; when a section of hinged portions of the door frame is raised, the pocket is exposed for vacuum-cleaning.

The natural question about operating sliding doors with both hands full was asked by TOPICS' reporter. "They are almost never fully closed," replied Miss Buck. "They permit complete privacy, yet are open just enough for a staff member to slide the door open with a slight push of the foot or elbow. They move noiselessly, very effortlessly."

Another feature of the floor is a "lazy-susan" revolving circular charting desk in the main nursing station. A separate conference area where doctors can consult privately is installed adjacent to the charting desk, and doctors, in the privacy of the conference area, can reach any chart on the desk through an opening in the conference-room window. Doctors and nurses sitting in fixed positions turn the charting desk to reach the chart rack wanted and all charts are readily available to eight seated persons. After writing orders on the chart, the doctor places it in a pocket beside the chart holder. In this way, the nurse knows immediately that an order has been written.

There is a "family" room where relatives of the seriously ill can wait. There are two isolation rooms, with toilet, lavatory, cleaning facilities and workrooms with trays and other equipment.

"We have had numerous letters from hospitals scattered throughout the country," said Mrs. Ancker, "and from one in Paris, asking us for blueprints and other information and suggestions from our experience here at Lower Bucks County Hospital. We even received a letter from a hospital in Budapest, Hungary, requesting information. You may imagine how deeply we appreciate such letters, and we are more than rewarded if we have helped, in any way, the beginnings of similar units elsewhere. But our greatest reward is right here at home, where by their warm responsiveness, members of the community have told us they know we are ready to give them the very best nursing care, whenever they need it, for as long as they need it, and with as much peace of mind possible under the circumstances."

The following abstracts were taken from speeches presented at the AHA convention, held Aug. 29-Sept. 1 in San Francisco.

Hospital Can't Be Health Center Without Changing Primary Function

Much contemporary discussion of preventive medicine can only be classified as utopian. The central function of a hospital is, and in my opinion must remain, treatment. It is difficult to see how a hospital can become a true health center without sacrificing its primary essential function: treatment.

The distinguishing characteristic of a true health center, on the other hand, must be not treatment so much as prevention of disease and disability. The public does not seem ready to accept this concept, nor do the professions offer anything positive enough to persuade the public of the validity of the concept.

There is no doubt in my mind, however, that the health center is coming, and hospitals can play a part in bringing it to pass. They can steadily become more comprehensive; they can encourage geographical centralization of health-care services; they can support education and research (for most hospitals this would be done indirectly by making funds available for scholarships and special studies); they can encourage, organize, or conduct health-education programs for the public, such as physical fitness testing, early detection programs, and immunization; they can adapt the financing of health services to payment for keeping well instead of paying only the unwelcome costs of sickness.

A comprehensive hospital or health-service center is probably what most people mean by a health center. Great medical centers of today are such comprehensive hospitals with extended functions. Though it is tempting to call them health centers, they deal, as we all do, primarily with sickness and disability.
—Philip D. Bonnet, M.D., administrator, Massachusetts Memorial Hospitals, Boston.

More Active Infections Committees, Better Reporting Systems Needed

A review of the recent history in the understanding of hospital infections and, more particularly, hospital-associated staphylococcal disease shows only moderate progress. We have experienced transition through a long era of basic scientific recognition through a more recent era of popular medical recognition.

A stage of universal recognition of the problem at the local level has been attained. Infections committees are commonplace, but have not always begun to provide for both "alarm" and "analytic" functions for the hospital. The pattern for such a program is becoming clear.

When such surveillance programs have existed over the last few years, interesting data have accumulated. It may be recognized that there are fluctuations in prevalence of specific staphylococci and infections, not always associated directly with control efforts in use. Then "natural" fluctuations should be kept in mind before changes in prevalence are too quickly attributed to the control effort recently instituted.

Finally, a plea is made for more prompt recognition of changes in prevalence of staphylococcal disease in the community.

To aid in this effort, every instance of confirmed or suspected hospital-associated infection should be reported back to the infections committee of that hospital. This includes information contributed by the local physician, by the public health agency, or by another hospital. Each community of health personnel should join in devising such systems of reporting.
—E. Russell Alexander, M.D., chief, surveillance section, epidemiology branch, Communicable Disease Center, Public Health Service, Atlanta, Ga.

Determining Staffing

Part II:

This is the second installment of the article which was awarded first prize in the 1960 HOSPITAL TOPICS *editorial competition for graduate students in hospital administration. In Part I, which appeared in the October issue, the author discussed methods of cost analysis and described the organization of the pilot study.*

Work sampling is a technic for analyzing work which employs the random sampling theory. It is a measurement technic for the quantitative analysis, in terms of time, of the activity of men, or of any observable state or condition of operation.

A work-sample study consists of a large number of observations taken at random intervals. The whole theory is based upon fundamental laws of probability. In taking the observations the state or condition of the object of study is noted, and this state is classified into pre-defined categories of activity pertinent to the particular work situation.

From the proportions of observations in each category, inferences are drawn concerning the total work activity under study. The ratio of the number of observations to a given state of activity to a total number of observations taken will approximate closely the percentage of time that the process is in that given state of activity.[1]

The application of work sampling was first made by L. H. C. Tippett in the British textile industry in 1935. Later, under the name "ratio-delay," it received considerable attention in the United States in 1940 through the efforts of Robert Lee Morrow. C. L. Brisley of the Wolverine Tube Division of the Consolidated Copper Co. is generally credited with originating the expression "work sampling" in place of the term "ratio-delay" in July, 1952.[2]

The work-sample method has many advantages:

1. Measurements can be made with a pre-assigned degree of reliability.
2. Work can be measured by sampling in many instances in less time and at less cost than is required by other methods.
3. The analyst makes an instantaneous observation of the personnel at random intervals during the working shift, thus making prolonged time studies unnecessary.
4. No stopwatch or other timing device is needed for work sampling.
5. Work sampling may be made over a period of days and weeks, thus decreasing the chance that day-to-day or week-to-week variations may affect the results.
6. Crew-type operations such as nursing can be readily studied by a single analyst.
7. Work sampling produces fewer complaints from the workers under observation.[3]

The first of several steps in conducting a work-sample study[4] is to define the problem. In this instance it was to determine the percentage of nursing time by nursing-service classification that was spent productively and nonproductively, in order to define the most efficient nursing staffing patterns in an intensive-care unit.

Productive time was that time spent by nursing that would directly or indirectly benefit the patient. Nonproductive time was that time spent by nursing that did not apparently benefit the patient.

The second step is to develop a realistic sampling plan. Through conferences with the director of nursing of the pilot hospital, nursing surveys[5] and actual observation of the nursing service on duty, a list of nursing elements was compiled. These were divided into five categories:

Direct nursing care – doing something to or for a patient in order to improve or maintain the patient's health, comfort, or well-being.

Indirect nursing care – activity necessary to maintain the facility (i.e., material, equipment, supplies, utilities, etc.) and staff so that direct effort can continue without interference or interruption.

These first two categories were included under productive time.

Miscellaneous – any off-floor activity which can be related to nonproductive effort.

Delay – nonproductive time whether personal, idle (nothing to do), or waiting (necessary delay).

Reassignment – time personnel spend away from the unit under study, because of reassignment to another station.

The last three categories were included under nonproductive time.

Under each category there are a certain number of elements. Under **direct care** there are the following:

Treatment – consists of administering internal or external medication or application such as compresses, dressings, ointments, infusions (but not injections), etc.

Assisting – is helping person giving treatment by holding items or patient, handling something, mak-

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Patterns for an Intensive Care Unit

The Work-Study Sample

By Edward P. Robinson*

ing adjustments or other intermittent action.

Measurement — consists of taking temperature, pulse and blood-pressure readings and any immediate preparation or clean-up or put-away involved in the duties, such as shaking a thermometer, wrapping patient's arm for blood pressure, etc.

Injections — includes any shots given.

Patient's personal needs — consists of actions to maintain or improve the patient's physical or mental comfort and includes such things as bringing bed pan, giving patient water, giving back rub, straightening covers (but not making bed), or simply holding patient's hand. This also would include shaving or wiping face (but not bathing) and making the patient comfortable.

Handling patient — includes moving or manipulating patient in or out of bed.

Feeding — consists of actually feeding the patient (i.e., spoon feeding, use of straw, use of large syringe and tube, etc.).

Oxygen-suction administration — consists of setting up or regulating the pump mechanism or accompanying instruments, tubing, containers, etc.

Assisting — consists of giving aid to person administering oxygen-suction by such acts as lifting, placing, holding, etc.

Bathing — cleaning patient over-all.

Making bed — with patient in or out of bed — consists of changing the linen. (Simply straightening the covers goes under *"Patient's personal needs."*)

Writing medical records — consists of writing information concerning the patient in the nurse's notes. Written material, such as a laboratory stat requisition which becomes part of the medical record after it performs another function, falls under *"Indirect care -paperwork."*

Reading medical records—consists of reading information or instructions concerning the patient in order to determine the patient's nursing needs.

Preparation—consists of incidental acts such as getting material out for use, putting it away after use, and cleaning up miscellaneous instruments used for care of a patient.

Washing hands — refers to washing of hands by any nursing personnel before or after handling a patient. This is a necessary part of the job and is not personal time. This includes putting lotion on hands to keep them from becoming too dry from excessive washing.

Observation — consists of watching a patient to determine condition, needs or reaction to something.

Other — any activity falling into the definition for direct nursing care but not included in the above elements.

Under **indirect care** there are the following elements:

Paper work — consists of writing any information, directions, requests, reports, etc. other than nurse's notes or medical records. It includes handling the paper worked on (i.e., folding, placing it in drawer or mailing envelope, giving it to someone else). It includes such items as filling out requisitions for supplies or for professional services such as laboratory, filling out rosters of patients or nursing personnel, and writing general reports to be submitted to nursing supervision.

Telephone — consists of using the telephone (for business reasons).

Supervision — consists of giving or receiving directions or instructions, except that briefing of the next shift to come on the floor comes under *"Conferring with I.C.U. nurse,"* and receiving instructions from a doctor falls under *"Conferring with doctor,"* listed below.

Conferring:

—with doctor — consists of any discussion with a doctor related to patient care.

—with patient — consists of any conversation with the patient.

(Continued on next page)

–with visitor – consists of conversation with the patient's visitors.

–with I.C.U. nurse – consists of consultations or discussions with other nursing personnel in the unit in regard to patient care. This does not include supervision or personal conversations.

Other–any activity falling into the definition for indirect nursing care but not included in the above elements.

Under **miscellaneous** there is the following element:

Off floor – consists of any time when the individual is not actually in the unit being studied except when reporting late to work, which is personal time. It includes meal periods.

Under **delay** there are the following elements:

Idle – personal –

Idle – completely inactive

Personal – doing something unrelated to work, such as drinking water or carrying on a personal conversation.

Waiting – ready to do something but unable to until someone else performs a necessary prerequisite, for example, waiting for the aide to put up a screen before bathing the patient.

Reassignment is defined as time spent away from the unit under study because of reassignment to another station.

These definitions were deemed most appropriate to the particular pilot study. Other studies may wish to add or delete categories and redefine terms as adaptable to their own needs.

Each of these elements were reviewed numerous times to assure that all nursing duties in the pilot intensive care study were included.

There are certain technics to conducting a work sample.[6]

1. No questions should be asked of personnel concerning what they are doing, because this will create an atypical situation.

2. No conversations should be engaged in with the personnel for the same reason.

3. Personnel being studied should not be helped by the observer in doing anything in the way of work, for the same reason.

4. Additional work shou'd not be imposed upon personnel during the study.

5. The proper observation method would be to enter the study area, observe what the personnel are doing, tally this on the form in the appropriate blocks and leave the study area until the next observation.

6. What the personnel are doing, not what they eventually will do, should be marked down (i.e., if personnel are idle when the telephone rings at the instance of observation, one should mark down "idle," not "answering the telephone," which it appears they will eventually do).

7. Observations should be made at the proper times.

8. Biasing habit patterns should be avoided in making observations. For example, graduates, students, practical nurses, and nurse's aides should not be observed in the same order each time, because they will anticipate your movements.

9. The use of colored pencils is recommended, so that each observation cycle can be marked a different color. This later enables the analyst to determine what, for example, the practical nurse was doing while the graduate nurse was making a bed.

The third step in the study is the selection of the proper number of observations for the desired reliability. A preliminary study was made for the first two days to gain percentage figures for productive and non-productive time. Productive time amounted to 55 percent; nonproductive time, 45 percent. The accuracy of the results of a work-sampling study is affected by the number of observations taken. The formula showing the relationships between the degree of accuracy and the number of observations for the 95 percent confidence interval selected is as follows:[7]

$$Sp=2\sqrt{\frac{p(1-p)}{N}} \quad or \quad N=\frac{4(1-p)}{S^2 p}$$

S=.05, standard error of a percentage

p=.45, percentage occurrence of an activity or delay being measured expressed as a decimal

N=1,964.2 observations . . . 1,964 observations are necessary to achieve a 95 percent confidence interval within a degree of accuracy of five percent.[8]

Thus, 1,964 observations per nursing shift give a 95 percent confidence interval within a five percent degree of accuracy.

The study was to take six days for each nursing shift, or a grand total of 18 days, divided as follows: January 18-23, day nursing shift (7 a.m. to 3:30 p.m.); January 24-29, evening nursing shift (2:45 p.m. to 11:15 p.m.), and January 30-February 4, night shift (11 p.m. to 7:15 a.m.).

It was noted from nursing time sheets received prior to the beginning of the study that the scheduled assigned nursing personnel to be observed would total seven for each shift. Each work-sampling trip to the unit constituted one cycle. Seven people to be observed in this one cycle equaled seven observations per cycle. Therefore, it was decided that 300 cycles of seven observations each would give 2,100 observations per nursing shift, which was above the necessary 1,964 observations to achieve the desired reliability.

However, because nursing personnel were sometimes reassigned according to patient load for a particular day, thereby reducing or increasing the predesignated figure of seven, observations per week varied.

On the day nursing shift, 2,156 observations were taken during 303 cycles, which gave a 95 percent confidence interval within a five percent degree of accuracy. During the evening nursing shift, 1,698 observations were taken on 300 cycles, which gave within a six percent degree of accuracy; on the night nursing shift, 1,216 observations were taken on 300 cycles, which gave within a seven percent degree of accuracy.

Observation cycles were selected at random times from a table of random numbers.[9] A nursing shift

consists of 510 minutes. Therefore numbers from 0 through 510 would be selected and considered in groups of six, for the six working days studied per shift.[10]

Using the table of random numbers it was found, for instance, that the beginning six three-digit numbers selected were 240, 013, 124, 500, 006, and 505 (see "day shift" chart below).

These were then arranged in numerical sequence (column 3) as 006, 013, 124, 240, 500, and 505. The days (column 4) remained with the numbers. Thus random number 240 which was selected for day one (column one) still was day one in column four. The times were then added to the starting time of the day shift, which was 7 a.m. Therefore 240 minutes added to 7 a.m. equals 11 a.m. (column 5) for day one.

Day Shift

Day	Random No's. Selected	Arranged	Day	Time
1	240	006	5	7:06 a.m.
2	013	013	2	7:13 a.m.
3	124	124	3	9:04 a.m.
4	500	240	1	11:00 a.m.
5	006	500	4	3.20 p.m.
6	505	505	6	3:25 p.m.

The selection would continue until 300 cycles had been selected for the six-day period. One day would have 68 observations, another day, 44 observations, and so forth. A different number of observations might be taken per shift as long as the total reached 300 cycles for the six-day period. If the same random numbers occurred twice during the same interval, such as 3 p.m. this counted as a double reading. (See cumulative random observation distribution sheet, Table 1.) The utmost care was taken to assure the randomness of the sample.

The last step in the study is to hold a briefing session with the personnel being observed to explain the reason for the study and how it will be conducted. It is essential that such a session be held prior to the beginning of any work-sample study, so that there will be no misunderstanding as to the reasons for the observations. The personnel in our study were informed that this study in no way was intended to reflect upon any of the personnel.

The study began on Monday, January 18, 1960, and concluded on Thursday, February 4, 1960. The recorded work-sample observations taken of the nursing personnel assigned to the pilot study over the three-week period were then interpreted and evaluated, through discussion of duties with the director of nursing and hospital job descriptions, in order to establish a maximum utilization staffing pattern for the soon-to-be-opened regular intensive-care unit.

Limitations and Variable Factors

In all studies, certain factors will be limited because of the necessities of the situation or will be variable

(Continued on next page)

Table I—Cumulative Random Observations. Distribution for the Day Nursing Shift for a Six-Day Period

Time	Observations	Time	Observations	Time	Observations
0705	4	1000	4	55	7
10	1	05	2	1300	1
15	6	10	3	05	1
20	5	15	2	10	2
25	3	20	1	15	1
30	4	25	1	20	3
35	1	30	1	25	5
40	4	35	6	30	6
45	2	40	3	35	2
50	5	45	2	40	2
0800	7	50	5	45	
05	2	55	2	50	1
10	4	1100	3	55	2
15	3	05	1	1400	1
20	6	10	4	05	1
25	5	15	5	10	3
30	2	20	3	15	4
35	6	25	1	20	4
40	4	30	3	25	3
45	4	35	1	30	1
50	3	40	1	35	4
55		45	5	40	4
0900	1	50	2	45	7
05	2	55	1	50	2
10	6	1200	1	55	2
15	7	05	3	1500	3
20	3	10		05	4
25	1	15	1	10	3
30	5	20	5	15	3
35	3	30	4	20	3
40	1	35	4	25	4
45	5	40	1	30	2
50	3	45	1		
55	2	50	5		

Table II—Patient Statistics—Intensive Care Unit

	Week I Jan. 11-17	Week II Jan. 18-24	Week III Jan. 25-31	Week IV Feb. 1-7
A. Total of individual patients	12	11	11	15
B. Male patients	7	7	4	8
Female patients	5	4	7	7
C. Medical patients	6	3	5	5
Surgical patients	4	6	5	8
Medical/Surgical	2	2	1	2
D. Total days	39	39	46	48
E. Average length of stay	3.25	3.5	4.2	3.2
F. Admissions	11	8	5	8
G. Transfers out	6	3	3	7
H. Ceased to breathe	3/25%	2/18%	2/18%	2/13%
I. Occupancy percent	63%	66%	75%	82%

Week #1	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
Patients	4	6	4	4	6	8	3
Percentage	50	75	50	50	75	100	37.5
Week #2							
Patients	3	3	5	7	7	6	6
Percentage	37.5	37.5	62.5	87.5	87.5	75	75
Week #3							
Patients	6	8	5	7	5	5	6
Percentage	75	100	62.5	87.5	62.5	62.5	75
Week #4							
Patients	8	7	6	6	6	6	6
Percentage	100	87.5	75	75	75	75	75

from hospital to hospital. Limitations and variables of this study included:

1. The cost factors cited here would not necessarily be the same ones or the same combinations used in other hospitals. For example, admitting and reservations may be separate factors in one hospital or may be combined into one function in another hospital. The number of factors may also vary. The type and number of cost factors will depend to a great extent on the needs and desires of the particular institution.

2. Cost analysis method three is the most comprehensive because of its two distributions. However, many hospitals may wish to use cost analysis method one or two or some other type of cost determination. Selection of the method also would depend upon the needs and financial resources of the hospital, as method three, because of its detail, tends to be the most expensive of the three.[11]

3. Nursing duties and classifications may vary as to what is included in the functions of nursing according to the needs of the patient and the criteria of the individual hospital. Job descriptions and duties for graduate nurses, practical nurses, and nurse's aides may vary from hospital to hospital. Also, the needs of the patient at a particular period of his care may call for a realignment of nursing duties and responsibility needed for this particular period as opposed to other times of improvement or worsening of the patient's condition.

A job-classification survey was conducted in the pilot hospital nine months prior to the study. Nursing personnel selected were most qualified and adaptable to this type of concentrated care. Individual job descriptions defined the stratification of duties between the nursing services; however, as always, flexibility was maintained to meet the needs of the patient.

4. Certain hospitals may move into progressive patient care gradually through establishing one phase at a time, instead of starting with the total concept of all phases from the beginning.

5. The reliability of a study may fluctuate from the desired number of observations as a result of reassignment of personnel, which decreases the sample number. Because of the shortage of nurses in most hospitals, this factor must be considered. It is recommended that reassignments be held to a minimum during the study period or that a sufficiently large number of observations, in excess of the necessary reliability figure, be taken to cover this eventuality.

6. During the first few days of any study the personnel may tend not to be at ease because they are being observed. The pre-study meeting previously described under "work sampling technics" is one way of overcoming this feeling to a great extent. Another method is to observe the first few days on a trial-run basis and then throw out these results. This will serve two purposes: the personnel will then be at ease for the regular study, and the desired number of observations can be determined as described under work-sampling observation determination.

7. The pilot study consisted of eight beds. Patients selected for the unit were considered as those most in need of intensive care. This factor must be considered in transferring the results of an eight-bed study to a larger, functioning unit such as a 26-bed area. However, as a stabilizing factor it should be noted that while the degree of severity of illness may tend to vary between individual patients, the medical criteria established for the intensive phase would admit only those patients in need of such concentrated care, so that nursing patterns would be concerned only with critical patients.

8. Although Table II describes the type of illness by medical and surgical classification, time limitations and the vastness of the project prevented a more detailed analysis of all the diagnoses of those patients admitted to the unit.

9. The methodology presented herein was designated as a guide to predetermining staffing patterns in an intensive-care unit and to enable hospitals desiring such information as gained by the study to use the same procedures and to substitute factors and figures particularly applicable to them.

The final installment, in the December issue, will contain an interpretation of the findings of the study, plus the conclusions and recommendations made as a result of it.

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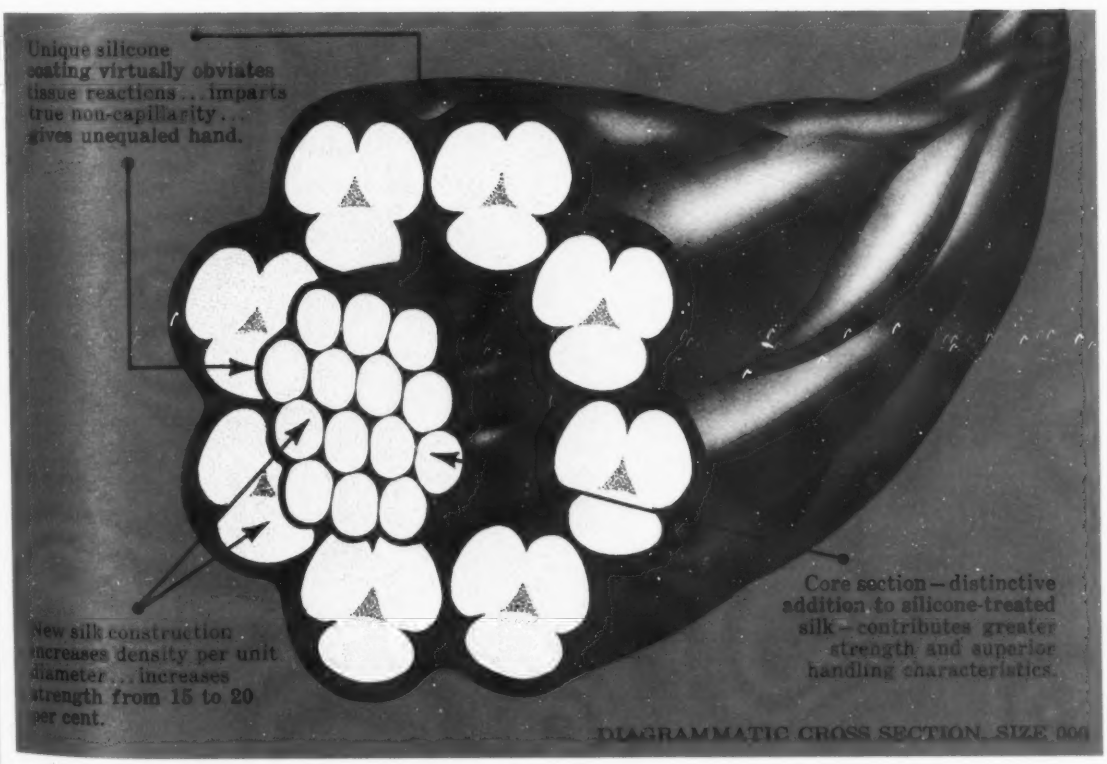
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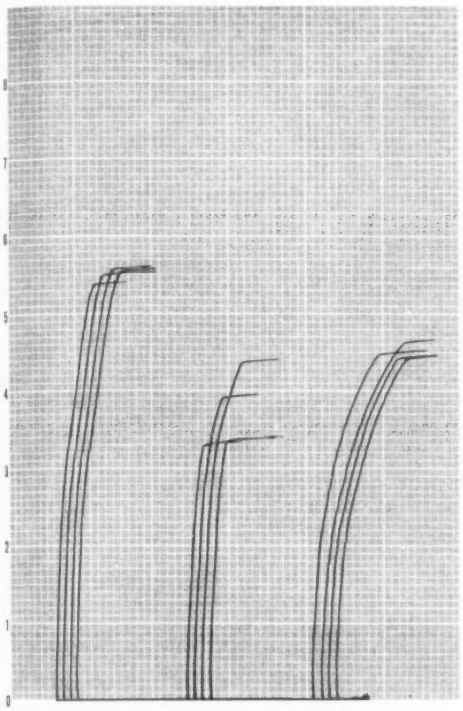

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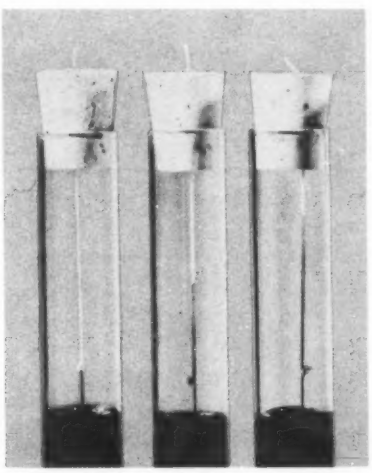

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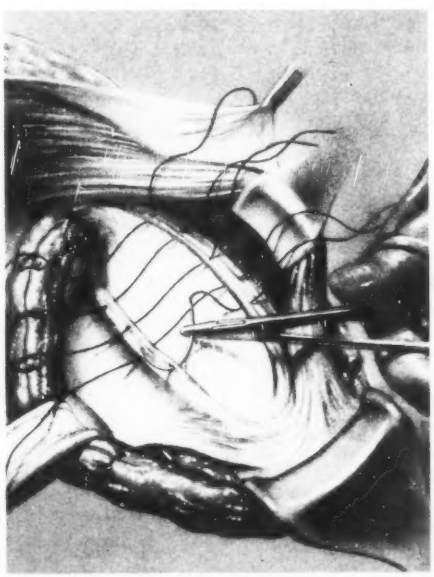

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HOW TO RUN A MEETING

By John G. Steinle and Ivan Belknap, Ph.D.*

The success of a meeting depends on a number of factors. Perhaps one of the most important is the character of the chairman. Though it is difficult to set down hard and fast rules for the actual conduct of a meeting, there are a number of "do's" and "don't's" which, if observed, can at least increase the value of a meeting to those who attend it. Many of these suggestions relate to the preparation for organization and reporting of the meeting.

Who should attend a meeting?

In planning a meeting one of the first things that must be determined is the list of persons who should attend. A meeting may be "closed" – limited to a selected group of invitees, or "open"–to anyone interested. For example, the meeting of department heads is "closed," but the meeting of the community to explain the hospital expansion plan is "open."

The size, community of interest, and knowledge which those present have of the basic subject matter will greatly influence the organization of a meeting. As a general rule, a meeting of a large group that is more or less heterogeneous in knowledge of subject matter and interests will require some staging. Persons who are to talk should be selected in advance, and some questions should be "planted" if there are to be questions and answers.

At an open meeting, emphasis should be placed on general principles rather than on detail and technics. A good rule is that an open meeting should be concerned with the "what"; a closed meeting with the "how." Thus, a meeting to discuss whether a hospital should establish a mental hygiene clinic should be open, while a meeting concerned with how the clinic would operate should be closed, except presumably to representatives of the medical profession, department heads concerned, and trustees.

How should the agenda be organized?

In preparation of the agenda, the first question that should be asked is: What are the objectives of the meeting? If this question is consistently kept in mind, many unnecessary meetings and manpower losses will be avoided. Never hold a meeting just to hold a meeting!

The reasons for holding a meeting can usually be broadly classified under the following or a combination of the following:

- To obtain facts, figures or advice for decision-making authority
- To arrive at a decision
- To establish the groundwork for making a decision
- To impart information
- To provide details on methods or procedures.

The purpose or objective of the meeting will affect the sequence of items. If the interest of the audience is more or less circumscribed, as in the case of a meeting of the department heads of the hospital, the following agenda sequence has been found to be effective: (1) matters of general information, (2) specific instructions, (3) discussion for decision-making, and (4) discussion for purposes of providing information. This sequence works best when the meeting is internal – within the hospital organization – and the administrator is acting as chairman.

Often a meeting will have on the agenda a number of items of which only one is really important. In these instances, it is a good rule to place the important item or items in the middle of the agenda, so that they will be reached after everyone is settled and before the audience becomes restless. It should be noted that in the suggested sequence for department-head meetings, the discussion for decision-making is positioned in the middle of the meeting. This is usually the most important function of such meetings.

The degree of organization of the body meeting may dictate the sequence of items on the agenda. For example, the regular monthly meeting of the board of trustees will follow a fixed pattern of committee

(Continued on next page)

*Mr. Steinle is president of the management consulting firm of John G. Steinle and Associates, specialists in institutional management and planning. Dr. Belknap is associate professor of sociology at the University of Texas.

reports before new business is reached. In every instance, possible items on the agenda should be considered by the appropriate committee and reported by that committee when the body meeting has a formal committee structure.

Often a group or person will be invited to a meeting for a specific purpose. The items relating to this group or person's interest should be first on the agenda. For example, when a consultant is invited by the board of trustees to make a report, the regular business should be conducted after his report is given. The guest can then be given an opportunity to withdraw from the meeting after his presentation.

Sometimes only part of the audience has an interest in certain items on the agenda. In these instances the agenda should be planned in two parts—a general session and a special session, with the limited-interest items last. A short "stretch period" between will give those not interested in the second part an opportunity to leave. It is always much better to have a small group actively interested and participating than one that is large, restless and uninterested.

What is the role of the chairman?

The chairman is responsible for the orderly conduct of the meeting. He must give an opportunity to be heard to every person who has something constructive to say on the subject. He must keep the meeting within the bounds of the pertinent subject matter and see to it that it proceeds according to the agenda. When decision-making is a part of the purpose of the meeting, he must follow an orderly procedure and obtain the majority opinion of the body by motion and vote. He must, with warmth and humor, keep the meeting moving, on schedule and fully rational. He must direct the keeping of minutes.

A good chairman usually introduces the subject. This may be done formally by following an agenda. In conducting the meeting, the chairman should concentrate on being courteous and decorous. It is a good idea to be conservative in his selection of stories and humor. He should restrict himself to the principal function of conducting the meeting and not use the chair as a rostrum for airing his views on each matter discussed. Even when he has something of major importance to contribute to the meeting, he should avoid saying it himself if he can get someone else to say it for him.

In keeping the meeting moving, it is well for the chairman to estimate the man-hour cost represented by those in attendance and thus the total cost of the meeting per hour. This, however, should not be carried to the extremes used by one minor government official in Washington, who always scheduled meetings in a non-air-conditioned room in summer and in a room with the radiator turned off in winter, a half-hour before lunch or a half-hour before quitting time. He was very proud of the effective way he obtained agreement.

It is the function of the chairman to encourage those with ideas to talk and those with talk to listen to ideas. An effective means of controlling a rambler or one who will talk up a marathon at a drop of a vowel is to defer the matter of that person's interest to the end of the meeting. This the chairman can do by saying: "Mr. Jones, I wish you would hold that until such and such item comes up on the agenda." Often by the time the item comes up, almost everything has been said.

For purposes of clarity, the chairman should present a summary of the meeting, stating the purpose, the points of agreement and disagreement, the areas of concession and compromise, and the formal actions taken by the body, even though the minutes are subsequently circulated to those in attendance.

Should minutes be kept?

If the subject matter is of sufficient importance to justify a meeting, it is of sufficient importance to keep minutes. All actions taken should be recorded. All subjects discussed should be listed, and if no action is taken or no decisions are reached, this should be noted. Such items are often referred to as "open items." A new chairman, before presiding at his first meeting, should read all past minutes. He should list all items that were pending from previous meetings and all "open items," and discuss with the group the possibility of rescheduling these items if decisions are needed.

Minutes should be prepared and sent to all participants the next day following the meeting or as soon as possible. The chairman should review the minutes in draft but be very careful to be objective in editing.

DO's FOR HOLDING A MEETING

1. List the persons who should attend the meeting according to subject matter and purpose of the meeting.
2. In preparing the agenda, first define the objective of the meeting.
3. Place the most important items in the middle of the agenda.
4. In every case possible, matters should first be considered by the appropriate committee.
5. The chairman must keep the meeting within the bounds of the pertinent subject matter and proceed according to the agenda.
6. The chairman should encourage those with ideas to talk and those with talk to listen to ideas.
7. Always keep minutes. If the subject matter is of sufficient importance to hold a meeting, it is of sufficient importance to keep minutes.

DON'T's FOR HOLDING A MEETING

1. Don't discuss technics before an uninformed audience.
2. Don't hold a meeting just to hold a meeting.
3. Don't invite people just to have a large crowd.
4. If chairman, don't use the chair as a forum to air your views.
5. If chairman, don't consider your role as that of an entertainer or comedian.
6. Don't consider that the main objective of a meeting is to finish on time.
7. Don't delay in getting out minutes.

Achieve Better Employee Relations With Modern Personnel Practices

By R. W. Gerard*

The structure and function of any hospital personnel department are directly related to the size of the hospital. Experience has proved that a well-developed personnel program is most effective when centralized and managed by one person. The person in charge of the personnel activity of a small hospital may be the administrator or office manager. A larger hospital may have a personnel director, responsible only to the administrator or his assistant.

It is essential today for every hospital to have established, written employee policies and procedures for hiring new personnel and for correlating fair employee practices and other similar legislative restrictions. Basic hospital employee hiring policies might deal with the following subjects:

1. Distinction between full-time, part-time, and temporary employees
2. The re-employment of former employees
3. The minimum educational, training, and skill requirements for a job
4. Consideration of all applicants regardless of color, nationality, or religion
5. The employment of relatives of present employees
6. The hiring of married women with families
7. Age limits for employment
8. Full-time work for applicants under age 18.

The personnel office is the first department which new employees visit, and first impressions here are lasting. Therefore, it is important to maintain a congenial and helpful atmosphere.

Orientation

Some persons should be assigned to each new employee as he starts work, to teach him his duties, to orient him to his new surroundings, but mainly to convey a sense of belonging to the hospital working family. The "buddy system" may be used to give the impression not that the new employee was hired to do a job, but that the job was given to him because he could do it. A department job-instruction manual will be helpful in orienting the employee correctly.

During orientation, the following hospital policies should be clearly explained and all questions answered about them so that no misunderstanding can occur: hours of work, pay day, holidays, vacation, sick time allowance, hospitalization, merit rating, promotion, pension plan, and other special employee benefits. The orientation program should be as complete as possible. This period is an adjustment state for the new employee. Starting off on the right foot builds lasting relationships between him and the hospital.

Personnel Records

Exact, up-to-date personnel records are the tools of good personnel administration. Good personnel records should offer proper evaluation of every phase of personnel activity and provide information for the consideration of employee promotions, change in employee status, salary changes, credit references, and justification of the hospital's action in discussions with department heads and supervisors.

Different methods can be used to maintain hospital personnel records, depending upon requirements of the hospital. One method, frequently used in small hospitals with few employees, provides that all personnel records be kept in an employee folder.

A second method uses an employee history card which has space for recording personal and family history, salary changes, job characteristics, educational

(*Continued on next page*)

*Director of personnel administration, Toledo (O.) Hospital.

advancement, and performance rating. The card should be used in combination with the employee's folder.

For large groups of employees, use of a visual Kardex file affords immediate reference to employee information. This system also condenses all pertinent personal and personnel information on an employee history card. Separate educational and job-description cards may also be used if the hospital wants a more refined record system.

The following employee records are usually necessary in setting up a personnel record system:

Employee application. The application for employment becomes part of a permanent employee record.

Individual employee folders. Into each folder is placed the individual's employment application, together with other hospital employment forms, reference letters, confidential papers, personnel test papers, physical report, and so forth.

Job control card. A hospital with a job evaluation program may use cards showing the job grade, job title, starting and final job salary, and complete job description and specification. This program can bring about the adoption of a salary-classification and job-control system, specifying required personnel quotas for each department. A merit-rating program may also be evolved from this information. A program using these systems can prevent unnecessary salary expense, improve job transfers, stop the creation of jobs without authorized justification, and subdue the build-up of unnecessary work functions.

Departmental Manual

Each hospital department can make a manual containing the latest department records and forms, written department procedures, future goals, and so forth, to give the new employee an idea of the department's operation and its relation to other departments.

Salary Administration

Each job has a proper salary. This can be arrived at by analyzing the tasks, duties and responsibilities in each job and setting a salary based on the relative importance of the job rank and on the current rates generally paid for the same or similar kind of work in the local labor market. Because of the varying degrees of work performance by individuals, it is desirable to have job salary ranges of minimum and maximum rates. Salary increases can then be awarded to the employee through a merit or performance program.

Employee Performance Rating

Almost everyone is looking toward the betterment of his welfare. Every employee, therefore, has a right to know how he is progressing on his job. A performance or merit rating can give an equitable account of an employee's working review. A performance or merit-rating program has many uses and will assist in the determination of salary increases, promotion, transfer, further training, employee responsibility, and future potential.

Promotion

Many hospitals have found it practical to promote from within, to make the best uses of the employee's skills and experience, to strengthen morale and tighten employee-employer relationships. Seniority and merit are two of the most important factors to consider in making promotions. Whether seniority should hold precedent over merit or whether merit should be the first basis for consideration can best be decided by the individual hospital.

Training

Formal or informal employee training programs are essential and beneficial in all hospitals. By helping employees develop their skills and strive toward better proficiency, a hospital automatically improves its patient care. Qualified personnel should be allowed to advance and be given freedom of action to use and create their ideas to benefit themselves, their fellow workers, and the hospital.

The training program should include work assignments with greater responsibility in order to widen spheres of interest and background and to assist in developing more creative and effective thinking. The program should be continued over a long period of time and should cover various phases of hospital operation, such as hospital policies, employee morale, human relations, communications, concepts of supervision, leadership conferences, and many other subjects broad enough to encourage the interests of anyone conscientious in wanting to achieve a higher goal.

An adequate labor source of potential administrative, supervisory, and technical personnel meeting hospital job standards should be available and ready to be promoted when they are needed. It is a disgrace and bad administrative judgment to recruit from the outside labor force without first exploring undeveloped talent on the inside. Possible trainees should be encouraged, or required, to take certain school courses to qualify for promotion. Job competition with adequate reward for the qualified man is the American way of life and should be the hospital way of life.

Employee Programs

Athletic and sporting events, dances, picnics, and holiday parties are often sponsored by the hospital, in some cases in cooperation with the women's auxiliary. Periodic physical examinations, a health clinic, medical discounts, and other health benefits may be offered to hospital personnel. It has become the practice of many hospitals to recognize long-term employees by yearly dinners, pins, financial awards, and gifts. Some hospitals give awards after 25 years; others recognize faithful service after five years.

Communication

The morale of any working group depends a great deal upon the effectiveness with which hospital policies and operating procedures are communicated within the hospital. For best results, communication should be short, sweet, and simple and very easy to understand. Communication is simply conveying your

thoughts clearly to the other person. Employees should be kept fully informed about hospital matters which affect them or their work. Grapevine rumors can quickly and easily destroy good will. If communication is simple, clear, and direct between administrative supervisors and hospital personnel, misunderstanding and unrest are less likely to occur.

Grievances

Any feeling or complaint of dissatisfaction from the employee is a grievance and denotes a negative outlook which in time will possibly result in reduced efficiency. It is most advisable, therefore, to take care of any employee grievance as soon as it arises. All grievances should be dealt with. Administration should honestly support the solving of any grievances. The personnel department should serve only in an advisory capacity or on an appeal basis.

It is best, of course, to try to solve all grievances at a supervisory level and not bring them before a grievance committee.

Safety

Employee safety has always been the concern of management. Safety rules on the job and the importance of employee safety should be brought to the attention of every worker at the time of employment. Safety training should be included in the over-all hospital training program. A safety committee set up to promote a good hospital safety program should be organized to cooperate closely with management. Safety can never be oversold.

Retirement

A new trend for employee welfare, worth consideration by every hospital, is that an employee must contribute toward his future retirement pension. Consequently, the cost of the pension program becomes charged against patient income. Pension programs vary in many aspects, and each one should be geared to the best interests of a particular hospital. A retirement program helps hospitals to compete in the labor market. Other advantages are: reduced employee turnover, improved employee morale, increased job security, tax deduction, and the fact that the program demonstrates the hospital's personal interest in employees.

Today more than ever, hospitals need to experiment, to keep an open mind, and listen to the ideas and suggestions from the personnel who work in hospital departments. They are closest to the work—and they deserve a chance for expression. People make hospitals. Your hospital is only as good as you and your employees want it to be.

Keeping Track of Turnover

By Leonard R. Stom*

Personnel turnover is a problem in many hospitals. To obtain information on its incidence in our hospital and the reasons for it, we designed a multiphase monthly report form for tabulating turnover statistics.

The form is in four parts. The first (see illustration on next page) shows turnover by departments. It tells how many employees were hired in each department during the month and how many left it; gives the percentage of turnover within each department and also the percentage each department has in the total hospital turnover. The final column shows the percentage each department has of the total staff.

The percentage of turnover within each department is derived by dividing the number of full-time separations by the full-time staffing at the end of the month and multiplying by 100. Part-time employees are not included in the percentages.

The percentage of total hospital turnover is determined by dividing the number of separations from a particular department by the total number of separations for all departments and multiplying by 100.

The total hospital percentage of turnover for the month is derived by dividing the total number of full-time separations of all departments by the total full-time staffing of all departments at the end of the month and multiplying by 100.

The second form lists reasons for termination of employment. It has two sections: one for employees who resigned and one for those who were discharged. Column headings list the frequent causes for termination. In the section for information on employees who resigned, the headings are: school, home responsibilities, wage or hours, health, a better job, moving out of city, work conditions, no reason given, and miscellaneous.

The column headings in the section for discharged

(Continued on next page)

*Director of personnel, The Methodist Hospital, Houston, Tex.

employees are: unsatisfactory work, attendance, attitude, health, conduct, undependable, and miscellaneous.

The third and fourth forms in the report are for recording figures on the length of service of terminated employees, and on termination by job titles.

A six-month tabulation is done for the periods of July through December and January through June. The monthly reports are combined and the totals averaged. Only over a period of time, we believe, will patterns emerge which can be evaluated and corrected, if necessary.

In analyzing the reports for one year, 1958, we found the following:

Reasons for terminations: resignations—67.40 percent; discharges—32.60 percent.

Of those who resigned, the greatest percentage were moving from the city. It seems that medical personnel are quite transitory. Also, because of the present shortage in some critical categories, such as nurses, we welcome even a short term of employment.

The large group that left to obtain employment offering more opportunity – 7.29 percent – has suggested the need for instituting a re-evaluation of promotional procedures.

The large number resigning for health reasons – 9.27 percent – included resignations because of pregnancy. But it also suggests possible overconcern with individual health or depression resulting from working with the sick.

Many employees left to go to school. Perhaps this figure could be reduced by employment of more individuals in an older age group.

Home responsibilities were given as the reason for termination by 7.45 percent. Within this group, 37 percent left to care for their children. Because the hospital staff consists mainly of women, this type of turnover will probably continue. The problem might be alleviated by establishment of a hospital day nursery for children of employees.

Working conditions that were too taxing accounted for the resignation of 4.19 percent. Some correlation can probably be assumed between these resignations and the fact that our average hospital occupancy was 102 percent.

Among the discharged employees, 7.27 percent were fired because of absenteeism. This figure deserves serious consideration. Discharges for unsatisfactory work performance, which represented 10.33 percent, are directly related to poor selection, inadequate training, or a combination of the two.

An exit interview is held in the personnel department with every employee who leaves, whether he has resigned or has been discharged. These informal interviews have been very enlightening in bringing out the true reasons for termination, and often they provide interesting evaluations of the organization.

Analysis of figures on termination by length of service brought out these interesting facts:

—44.86 percent of the turnover occurs within the first three months of employment, and

—79.55 percent occurs within the first year. Only 20.45 percent occurs in employees with more than one year of service.

Better methods of selection, orientation, and training might lower the turnover rate and reduce the percentage of short-term employees. Separations occurring among employees with greater length of service generally reflect limited promotional opportunities.

The average time spent each month in compiling the turnover report is three hours and 55 minutes. It also serves as a monthly audit of personnel staffing.

The report is distributed to every department head and reviewed with the departments which have an apparent turnover problem. We think that awareness of the factors related to turnover has stimulated a renewed interest which can aid in lessening our problem.

Though this report has definite diagnostic limitations, it is a useful device. We believe that over a period of time, patterns will emerge which will enable a greater depth evaluation of factors causing turnover.

THE METHODIST HOSPITAL
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Figure 1

STAFFING AND TURNOVER PERCENTAGE FOR MARCH 1959

DEPARTMENT	1 1st of Month	2 End of Month	3 Accessions	4 Separations	5 Intradepartmental Turnover Percentages	6 Percent of Total Hospital Turnover	7 Percent of Total Hospital Staffing
Administration	7(2)	8(2)	1	0	-	-	.68
Accounting	31(5)	29(7)	1(1)	3	10.34	5.26	3.20
Medical Records	18(2)	19(1)	1	(1)	-	-	2.09
Public Relations	0	0	0	0	-	-	-
Religious Activities	3	3	0	0	-	-	.33
Personnel	4	4	0	0	-	-	.44
Admitting	12(1)	12(1)	0	0	-	-	1.32
P.B.X.	8(1)	8(1)	0	0	-	-	.88
Building Services	70(3)	69(4)	2(1)	3	4.35	5.26	7.60
Power Plant, Maint. & Laundry	96	95	5	6	6.32	10.52	10.46
Beauty Shop	4(1)	4(1)	0	0	-	-	.44
Barber Shop	1	1	0	0	-	-	.11
Dietary	118(11)	119(12)	10(3)	9(2)	7.56	15.79	13.11
Blue Bird Clinic	3(3)	2(3)	(1)	1(1)	50.00	1.76	.22
X-Ray	15(2)	15(2)	0	0	-	-	1.65
Laboratory	36(11)	34(10)	1	3(1)	8.82	5.26	3.75
Anesthesia	10(1)	9(2)	1(1)	2	22.22	3.50	.99
Pharmacy	4(1)	4(1)	0	0	-	-	.44
E.K.G. & B.M.R.	4(1)	4(1)	0	0	-	-	.44

20 Causes of Accidents in Older Patients

By Allen Podell*

The Brooklyn Hebrew Home and Hospital for the Aged has a full diagnostic, therapeutic, surgical and rehabilitation program for the more than 1,000 residents, who have multiple diagnoses requiring all the skills which the medical and ancillary professions have to offer.

In caring for this multitude of people, whose age average is 83, many problems besides medical care are constantly taxing our trained staff of doctors, nurses, and therapists. A major problem – one which faces the staffs of most homes and hospitals for the aged—is the constant threat of injury to the geriatric patient through accident.

Older people are usually semi-invalids who are not able to walk because of physical or mental disability. In many ways, the geriatric patient can be compared to the pediatric patient. Ambulation is not always possible; incontinence is a problem; and assistance in feeding, dressing, and bathing is often necessary. In addition, the geriatric patient is often senile and unable to communicate effectively.

A study was undertaken by the author to determine the major causes of accident in our hospital and what could be done to prevent them. Here is what we found:

Accidents happen because elderly patients:

1. Are not sure-footed.
2. Have impaired sight and hearing.
3. Receive sedation at night.
4. Awaken suddenly and do not recall their whereabouts.
5. Stumble over objects and furniture that are out of place.
6. Slip on floors which they make wet through incontinence and spillage.
7. Get dizzy in the toilet.
8. Misjudge distances.
9. Try to help one another unsuccessfully.
10. Lean for support upon unstable objects.
11. Climb over bedside rails.
12. Roll off chairs and out of bed.
13. Forget where they are.
14. Do not wait for help.
15. Refuse manual assistance.
16. Refuse help when it is offered.
17. Have poor balance.
18. Are impatient.
19. Try to get into or out of wheel chairs alone.
20. Do not wear shoes when ambulating, especially at night in caring for bathroom needs.

It is our opinion that these 20 factors are major causes of accidents in most homes and hospitals for the aged.

Since these factors have been identified, we have taken various steps to control them and cut down the accident rate among our patients. Among these are the use of better-designed equipment and the adaptation of standard furniture and equipment to meet the needs of the elderly patient.

For the patient with impaired sight and hearing, familiarity with surroundings is most important. The wanton transfer of this patient from one room to another causes many accidents. We have found that such a patient should not be transferred unless it is absolutely necessary. His bed should be of a height that does not require a footstool. His room should have heavy, well-balanced furniture and should be near the nurses' station and the bathroom.

The patient who receives sedation at night should have bed rails and a commode at bedside.

Areas with senile and incontinent patients should have good coverage by aides or orderlies who have been briefed on the patients in their care, and should have mobile equipment to take care of the patients' needs at bedside.

The patient who is a known bedside-rail-climber should be provided with half-length rails, and his bed height should be adjusted so that his feet can touch the floor when he is sitting in bed.

The poor walker and the impatient person should have a well-balanced mechanical walker available.

For the patient who has to spend a good part of his day in a chair and has poor sitting balance, a chair fashioned after a baby's high chair can be made. It should be a solid chair with a broad base and side arm, a slide-in tray, and a pommel to keep the patient from sliding down.

Most important in an accident prevention program is an alert, constantly vigilant staff. Old people neglect danger signals, and lose interest in their surroundings and in people. We must act as their eyes and ears and be ready to assist whenever necessary.

Our intensified program for patient safety has markedly decreased the occurrence of fractures and other disabilities which require many hours of intensive nursing care, and is enabling our staff to concentrate on caring for the critical patient and hastening his recovery.

*Administrator, Brooklyn (N.Y.) Hebrew Home and Hospital for the Aged.

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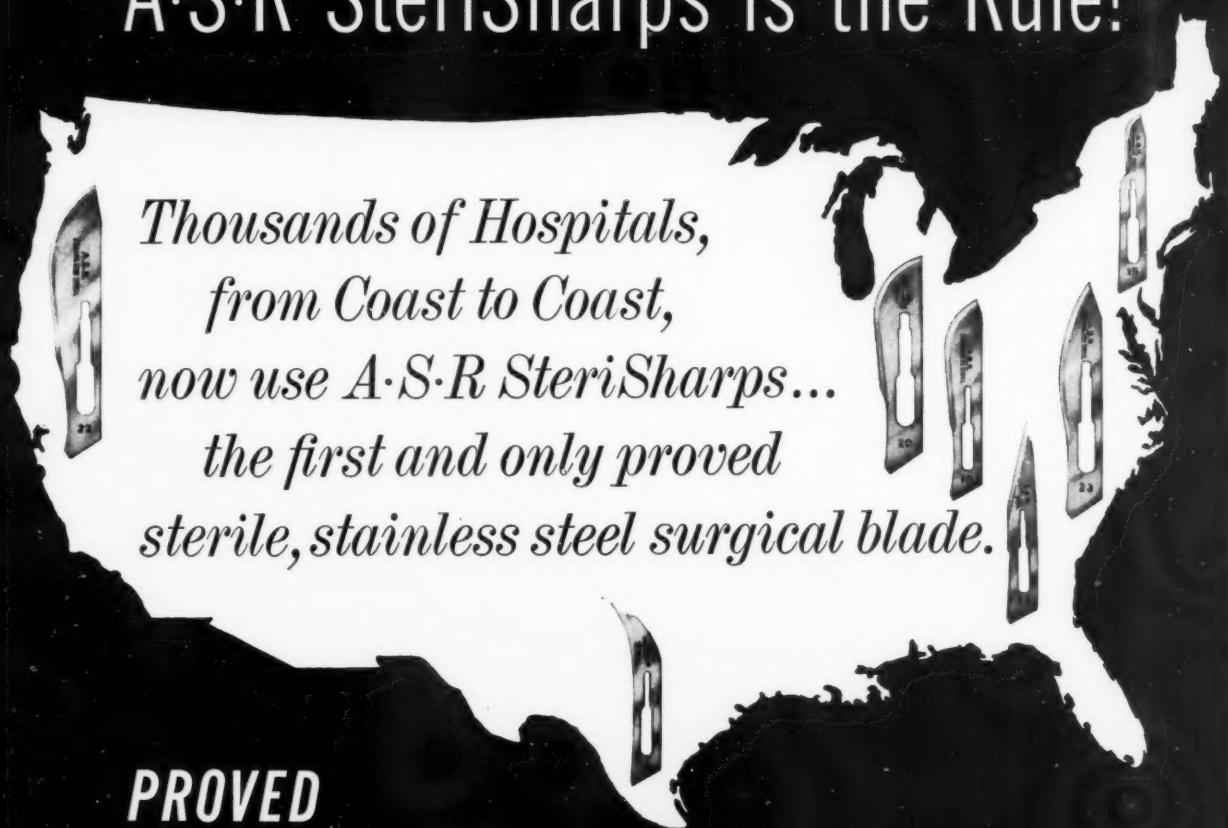

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Review of Hospital Lawsuits

By Leo T. Parker, Attorney at Law

• LEGAL RIGHT TO INFORMATION

A patient has a legal right to the information contained in hospital records and is entitled to copies of the records, a higher court held recently.

In *Wallace v. University Hospital, 164 N.E. (2d) 917,* the plaintiff, who had spent two months as a patient in the hospital, asked the court to compel the hospital to supply copies of her hospital records.

She had asked for the copies because she wanted detailed information concerning her injuries and treatment, as evidence in the determination of damages in a lawsuit filed by her against another person.

The hospital officials refused to supply them, even at her own expense. The lawyer for the hospital claimed that the records were the sole property of the hospital and that the patient had no legal right to obtain them.

The higher court ordered the hospital to furnish the records to the patient, saying:

"It is true that the original hospital records are the property of the hospital. Since they include the records of all births, deaths, nature and length of treatment and other information, their maintenance and custody is essential to the proper administration of the hospital. However, it is also true that a patient has a property right in the information contained in the record and as such is entitled to a copy of it."

With respect to an offer of the hospital's official to read the records to the patient's lawyer, the court said:

"The hospital's offer to read a technical treatment record encompassing a two-month period of treatment and recovery to the attorney is hardly adequate. In order to gain full benefit from the information, an attorney should have the opportunity to study the record at his leisure and to submit it to a medical expert of his own choosing for evaluation. Hospital's offer to read the record therefore labels their refusal to furnish the copy as an arbitrary and somewhat vain act."

Dismissal Is Valid

Negligence of a hospital's employee who caused death of a patient is valid ground for his dismissal, a higher court held in the case of *Vestal v. State Personnel Board, 3 Cal. Rptr. 619.*

Hazel Vestal was a psychiatric technician at the Modesto State Hospital. One day another employee, named McCough, attempting to spoon-feed a patient, placed food in her mouth, then held her head back and placed a towel over the lower part of her face so that both her nose and mouth were covered. The patient died from asphyxiation resulting from the aspiration of vomitus into the bronchi and trachea. Mr. McCough was found guilty in manslaughter prosecution, but Miss Vestal was found not guilty, although she assisted him.

Miss Vestal was dismissed by the state personnel board, and appealed to the higher court to compel the board to reinstate her. The court held that she was properly dismissed, and said that she was guilty of incompetency, inefficiency, inexcusable neglect of duty, discourteous treatment of the public, and other behavior incompatible with or inimical to the public service.

Union Can't Force Organization

Can union activities force hospital employees to become unionized? A higher Colorado court has answered this question in the negative.

The court explained that employees of a hospital, whether professional or nonprofessional, enjoy an employment status quite unlike most other employment relationships. Hospitals are dealing with persons who are third parties to the employee, and these third parties have by reason of circumstances a particular call on the solicitude of everyone connected with the operation of the hospital. Many of the labors of the hospital involve emergency and crisis; minutes may mean the difference between survival and death. To vest any organization with power to imperil efficient operation of such an institution is to give a power which no organization should want, or having it, should exercise.

The court's decision reversed a lower court ruling in the case of *St. Luke's Hospital v. Industrial Commission, 349 Pac. (2d) 995.*

Evidence was introduced showing that among the hospital employees were 174 persons whom a union sought to organize. Fifteen were in the engineering and maintenance department; 59 performed housekeeping duties, 27 worked in the laundry, and 73 were employed in the dietary department.

The Industrial Commission of the State of Colorado claimed that it had jurisdiction to conduct a bargaining-unit election and that the employees described

(Continued on next page)

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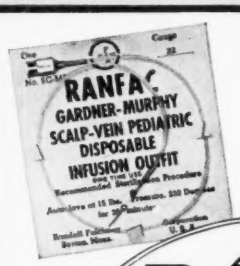

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constituted an appropriate unit. The lower court agreed with the commission.

The higher court, in reversing the decision, said, "It is true that the employees whom the union sought to represent were engaged in various kinds of manual labor, some of which were similar to those performed in hotels; but if the nature of the work itself is similar, the relationship of the work performed in a hospital to industry and trade is different from the relationship that work performed in a hotel bears to industry and trade.

"It is also true that such services were essential to the maintenance of the hospital, and those rendering the services can hardly be said to be engaged in industry or trade. The attendant problems – the picket line and the prospective refusal of others not involved to cross the picket line to take necessary supplies to patients – would follow. Organized action against the hospital would result in organized action against those so unfortunate as to be patients therein at the time of such action."

Lower Court Verdict Upheld

Unless testimony is presented which clearly shows that a lower court's verdict is erroneous, the higher court will approve the verdict. This rule of law is particularly applicable in suits against hospitals by injured patients.

For illustration see the case of *Neel v. San Antonio Community Hospital, 1 Cal. Rptr. 313.* The plaintiff, a woman named Neel, was a patient in the San Antonio Community Hospital when Miss Lenz, a nurse employed by the hospital, negligently put hydrochloric acid into her nose instead of nose drops. The patient sued the San Antonio Community Hospital for $7,500 damages for the injury she suffered.

During the trial, testimony was given that Mrs. Neel had suffered many physical ailments over the years prior to this injury. She was highly nervous. She had undergone considerable major surgery and was subject to allergic spells. She had suffered from sinusitis for about a year before the accident in question. When this accident occurred, she was in the hospital because of injuries received when she fell down a flight of stairs.

In view of this testimony the lower court awarded Mrs. Neel only $700 damages. She appealed to the higher court on the contention that the award was entirely too low. However, the higher court approved the $700 damage award, and said:

"Whether the two drops consisted of the hydrochloric acid alone or were in part the prescribed medicine is not clear. In any event, the interior of plaintiff's (Neel's) nostril was burned. Her attending physician testified that her stay in the hospital was prolonged for a period of two days because of the accident. There is no evidence that there was any loss of income by reason of disability occasioned by the burn. The only finding which would specifically indicate the extent of injury and damage is the finding that plaintiff (Neel) was damaged in the extent of $700."

Health Insurance Newsletter

This material is presented with the cooperation of the New York State Joint Legislative Committee on Health Insurance Plans, through John G. Steinle and Associates, special consultants to the committee.

Blue Cross Rates Up. Blue Cross subscribers in the New York City metropolitan area will be paying premiums 33.4 percent higher starting November 1 (*see* HOSPITAL TOPICS, *October, 1960, p. 11*). One feature of the settlement granting the rate increase is a new formula for reimbursement to hospitals, designed to avoid using inpatient income to pay for outpatient and emergency services. The new premium rates will also enable the plan to include additional benefits, with the standard family contract, namely:

1. Coverage of children from birth, including premature, except for nursery care and circumcision.

2. Increase in the private room allowance for subscribers in member hospitals from $10 a day to an amount representing the hospital's average charge for semiprivate accommodations. The allowance would be 50 percent of that amount during the 180-day discount period which goes into effect after the initial 21-day period benefit is exhausted.

3. An increase from $10 to $15 in private room allowances for subscribers admitted to non-member hospitals.

4. Coverage for mental and nervous disorders in nongovernmental hospitals up to 21 full benefit days and nine discount days in any one contract year or in any single hospital stay.

Inclusion of mental illness coverage was strongly advocated for all Blue Cross plans at a series of hearings on the problem conducted during 1958 by the New York State Joint Legislative Committee on Health Insurance Plans.

* * *

Home Care Grows. In at least two major cities in the country, care at home is beginning to play a role in easing the constant pressure on available hospital beds.

New York City's Blue Cross plan, Associated Hospital Service, is continuing to establish the feasibility of providing visiting nursing services in the home as an alternative to longer hospital confinement. Subscribers chosen by their attending physicians will be given home care by participating hospitals. This step was made possible by a recent amendment to the insurance law enabling Blue Cross to provide benefits for drugs, appliances, medicines, supplies, and other hospital services – excepting physicians' services – in connection with the program.

In Detroit, Michigan Blue Cross, with the cooperation of the Detroit Visiting Nurse Association, is conducting a pilot home-care program that enables patients to leave the hospital sooner and continue their care and recovery in the familiar surroundings of their own home with their family. After two months plan officials declared themselves very pleased with the results.

* * *

Steel Union May Build Hospitals. The United Steelworkers of America is reported planning to set aside $1,600,000 in pension reserves to construct its own hospitals and group practice medical centers.

The plan is outlined in a study released in September, after two years of work. The study envisages projects functioning in a manner similar to the Health Insurance Plan of Greater New York or the Kaiser Permanente Plan in California. Even more ambitious ventures into union-sponsored medicine than the United Mine Workers' chain of hospitals in West Virginia and Kentucky are also contemplated.

* * *

Blue Shield for Over-65 Group. Effective November 1, the medical surgical plan of New Jersey (Blue Shield) will join with Hospital Service Plan (Blue Cross) to offer a package prepaid health-insurance plan for New Jersey residents 65 years old and over.

New Jersey applicants will pay $16.46 a quarter for the new combination Blue Cross-Blue Shield coverage after meeting the same "reasonable" health standards now required of all persons seeking non-group enrollment. The plan offers 60 days of hospital benefits to age 70 and 30 days for age 70 and over, but requires $15 toward the first day's hospital cost and $6 a day for the next 14 days. A more comprehensive alternative contract is available at a higher premium.

* * *

New Bibliography Offered. *A List of Worthwhile Health Insurance Books* is the title of a new 26-page booklet published by the Health Insurance Institute, 488 Madison Ave., New York 22, N. Y. Copies are available on request.

Listings in the publication are grouped under such convenient headings as "health insurance books," "annual publications," "gerontology," "social security," and others. Also included are lists of organizations having a relationship to health and the financing of medical care, periodicals in the field, publishers' addresses, and additional pertinent information.

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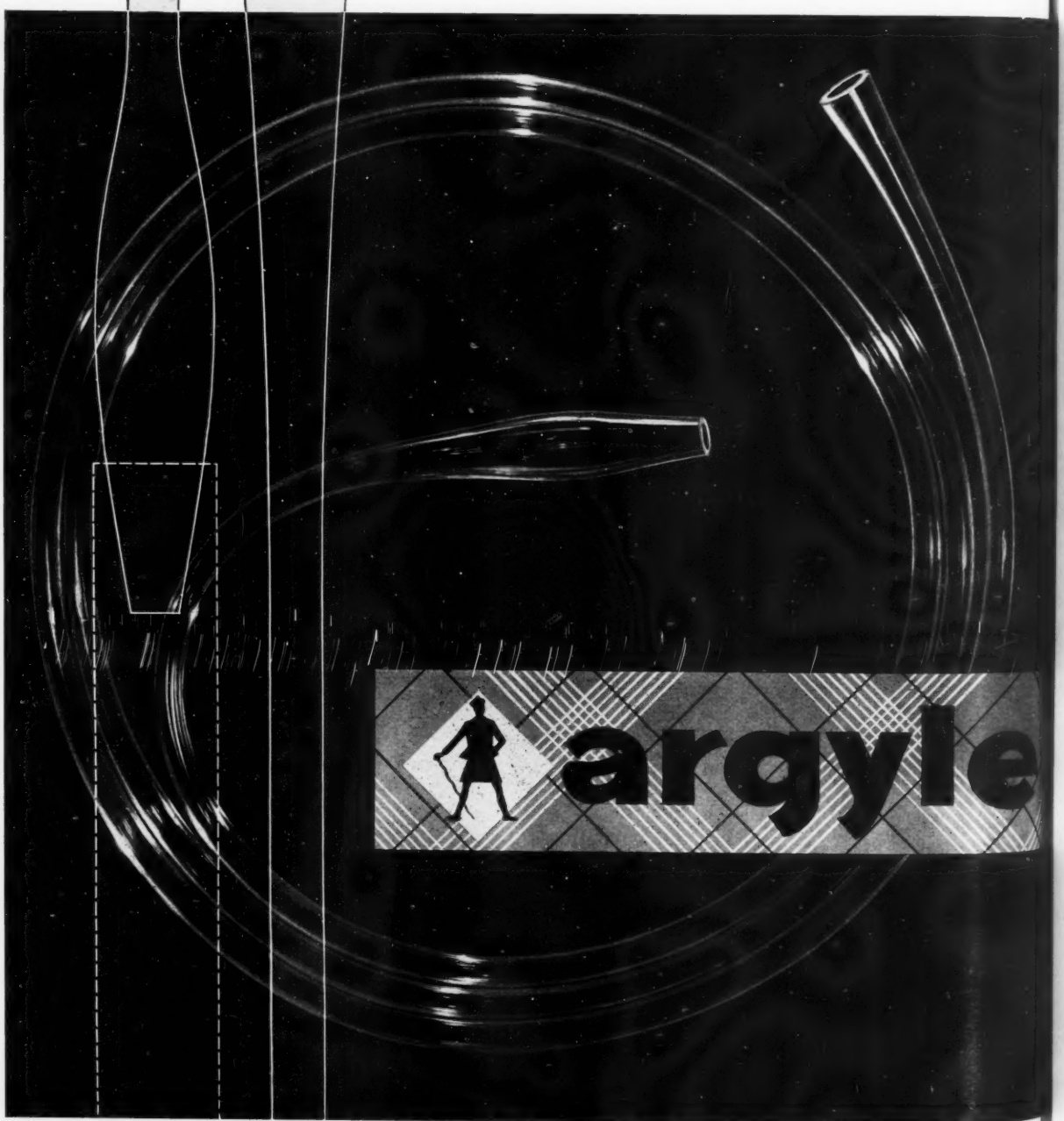

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For further information see postcard opposite page 126.

More Medicos Influencing Courtroom Decisions

Three out of four cases on U.S. court calendars require some sort of medical report and the impartial expert idea for medical testimony is spreading rapidly.

Nine states have already instituted or are considering programs whereby authoritative medical or judicial bodies agree to cooperate jointly in securing the testimony of impartial medical experts, it was reported recently in the *Journal of the American Medical Association*. The states are California, Illinois, New Jersey, Maryland, Massachusetts, Minnesota, Ohio, Pennsylvania and New York.

The American Association for the Surgery of Trauma has endorsed the idea that justice is best served by the impartial testimony of one doctor, rather than by two or more doctors presenting different viewpoints.

The plan's greatest success is in the city of New York, where it has been in operation for seven years. Figures there indicate that questionable claims have dwindled and fewer cases are coming to trial; reportedly because lawyers have come to recognize the proficiency of the physician testimony on matters of a medical nature.

AAMRL Requirements For Professional Status

The American Association of Medical Record Librarians announces that after January 1, 1965, only graduates of approved schools for medical record librarians will be permitted to write the association's registration exam to qualify for the professional designation, R.R.L., Registered Record Librarian.

Association bylaws were altered at the 1959 House of Delegates' meeting to include this provision. In the interim, until 1965, medical record personnel in medical record departments of hospitals, clinics or other distinctly medical facilities may apply to write the registration exam if they meet the following qualifications:

1) Have a minimum educational background of sixty semester hours credit from an accredited university or college, or graduation from an accredited school of nursing.

2) Have served successfully as a full-time medical record librarian in a hospital of 50 beds or over, or in a clinic or distinctly medical facility for five out of the six years preceding date of application—*or* are accredited medical record technicians who have completed three years of satisfactory service under a registered medical record librarian.

Additional information will be provided by the executive director, American Association of Medical Record Librarians, 840 North Lake Shore Drive, Chicago 11.

Four-year Deepfreeze Of Blood Is Safe, Reliable

A workable method of preserving human blood has been proven clinically effective, it is reported by researchers at the U.S. Navy Hospital, Chelsea, Mass. The process, described in a recent issue of the *Journal of the American Medical Association*, could revolutionize the operation of blood banks, now capable of storing blood for only three or four weeks.

The theory that glycerol, an alcohol, could prevent the damaging formation of ice crystals in red blood cells during freezing and thawing, was the basis for the experiment. The Cohn fractionator was used to add glycerol to the blood cells and to remove it after frozen storage. The glycerolized blood cells were stored in three deep-freeze lockers, two at —80 degrees C. and one at —120 degrees C. After storage, the cells were reprocessed into reconstituted whole blood or other liquid form for transfusions and placed under ordinary refrigeration. No relation was observed between the time of storage and clinical effectiveness even in units stored for as long as 44 months.

The process would mean reduced wastage due to spoilage of unused blood; assure supply of rare blood types without resorting to emergency appeal (allowing persons with rare blood types to bank their own blood for future use); alleviate the shortage of blood for operations requiring large amounts; and enable mass stockpiling of blood for use in the event of a nuclear attack.

Another advantage of the freezing process is that the breakdown of the blood into components makes it possible to tailor blood content to the needs of the recipient.

Processing technics and facilities to simultaneously process many units of blood are being developed.

The research project has already become a practical reality, with frozen-processed blood being used as the standard blood for transfusions at the Chelsea Hospital. The program was begun in 1956 under the joint supervision of the Department of the Navy and the Protein Foundation, Boston.

Nursing Education Called Antiquated, Inefficient

Nursing education to meet 1960 demands for nursing service is as antiquated as the assembly lines that produced World War II aircraft, says Edith Aynes of The National Foundation.

In a recent address to hospital administrators Miss Aynes — who is March of Dimes coordinator of information for professional education programs — told her audience that today's professional nurse must be educated to understand and reinforce modern medicine to the extent of more than 100 specialties. Nurses are having to shoulder many responsibilities previously carried by doctors, but they are subject to the pay and personnel policies determined by hospital administrators, who are businessmen operating with ledger entries in red.

"The actual physical care of patients," Miss Aynes stressed, "is being accomplished by practical nurses, nurses' aides, orderlies, attendants and volunteers with varying degrees of training who work under hit-or-miss methods of supervision learned by nurses by trial and error. The result is poor leadership, poor morale, loose or nonexistent standards of patient care, high personnel turnover, high cost, and inefficiency of operation."

THE LAB

Pathologists Investigate
• L. E. Tests
• Carcinoma

The American Society of Clinical Pathologists, the College of American Pathologists, and the Inter-Society Cytology Council met at Chicago's Palmer House Sept. 27-30. The following are abstracted from representative papers given.

Antibiotic Injections Foster Tissue Damage

Our study was undertaken to examine and classify comparative degrees of local reaction in tissues as a result of injections of various broad-spectrum antibiotics and their controls.

Oxytetracycline, solution of oxytetracycline in propylene glycol, tetracycline, chloramphenicol, and chloramphenicol succinate were the various compounds involved in the tests. Thirteen separate series, a total of 646 individual injections, were administered to rabbits.

Single and repeated subcutaneous injections, and single and repeated intramuscular injections were employed in the series.

Results of the study revealed that local damage to the tissues occurred after injection with any of the antibiotics. However, there was a considerable difference in the degree of damage resulting from the various antibiotics. The most severe degrees of necrosis and inflammation were produced by tetracycline and chloramphenicol succinate injections. The least toxic effects were produced by oxytetracycline preparations.

Withdrawal reactions were most pronounced in conjunction with subcutaneous and intramuscular injections of tetracycline and chloramphenicol succinate. Mild scattered degenerative changes in adjacent nerves occurred with similar frequency following intramuscular injections of tetracycline and oxytetracycline.

Study findings show that although there are differences in degrees of damage produced by various antibiotics, some local damage occurs with all of those studied. Important consideration should be given these effects, particularly in connection with cases requiring prolonged therapy.—*Daniel J. Hanson, M.D.*, department of pathology and the research institute, Mercy Hospital, Toledo, O.

Acquired Thrombasthenia May Alter Platelet Count

Deficient thromboplastin activity of blood platelets, as determined by the thromboplastin generation test, is a frequent finding in hepatic disease. Among 25 patients recently studied, 15 demonstrated evidence of thrombasthenia, including 11 with cirrhoses and two with acute hepatitis.

In four of the patients, normal readings resulted from routine clotting tests, such as prothrombin and clotting time, as well as platelet count.

Thrombasthenia was also observed in a number of hematopoietic disorders, including pernicious, myelophthisic, and aplastic anemias, and in leukemia, lymphoma,

(*Continued on next page*)

John J. Andujar, M.D., (l.), Fort Worth, Texas, incoming president of American Society of Clinical Pathologists, and Frank C. Coleman, M.D., president, College of American Pathologists, exchange congratulations after their elections.

One of the busiest of the scientific exhibits at the ASCP-CAP meeting was one demonstrating a new technic in testing L.E. cells, which enables all the sample L.E. cells to be viewed in a small area on the same slide. Jerzy Sikorski, M.D., resident pathologist, Hartford, (Conn.) Hospital, checks slide while Pola Mudrik, medical technologist, Mt. Sinai Hospital, stands ready to record results.

polycythemia, uremia, Gaucher's disease, and idiopathic thrombocytepenic purpura.

The functional defect may occur with or without a decrease in the number of platelets. A normal count can foster a false sense of security; platelet function must also be tested. Serial dilutions of the suspension of platelets in the test system may uncover borderline defects. The distilled water test – exposing platelets to hypotonic solution – is helpful in differentiating between primary and secondary thrombasthenia. – *Emanuel E. Mandel, M.D.*, associate director, medical education, and *Jack Lazerson* and *Regina Pemkus*, Mount Sinai Hospital, Chicago.

Dentists Could Detect Early Oral Cancers

Carcinoma of the oral and pharyngeal mucosa makes up about three percent of all cancers, and causes approximately 3,700 deaths yearly in the U.S. Estimates of the percentage of oral cancers that could be prevented by early detection run as high as 80 percent.

The oral cavity should be an ideal location for recognition of the early stages of oral cancer, including intra-epithelial and early invasive cancer. In spite of this expectation, however, few cases where these lesions have been discovered have been reported.

Theoretically, all oral cancers must pass through a curable stage. Detection at this stage depends on thorough examination of the oral cavity, including the pharyngeal mucous membrane, no portion of which should escape visualization and palpation.

Leukoplakia is regarded by many as a precancerous lesion. It was our observation that exact visualization of the leukoplakia oral lesions reveals differences in surface appearance, mucosal translucency, and marginal inflammation. These differences could be the basis for detection of early malignant neoplasms of the oral cavity.

Histologically, we classified early epithelial growths of the oral cavity as follows: hyperplasia; leukoplakia: dyplasia; carcinoma in situ; early invasive carcinoma; and carcinoma. In the last six years, we have diagnosed seven dysplasias, 10 carcinoma in situ, and 17 early invasive carcinomas.

Increased awareness on the part of dentists of manifestations of oral malignancies, and more extensive referral of patients with suspicious lesions for possible biopsy should substantially lower the rate of death from oral cancer.

As a result of thorough oral examinations given 10,178 patients during the past year at the hospital, 32 malignancies were found. Of these, 22 were in the early stages.– *Bernard Chomet, M.D., Jonas Valaitis, M.D., and H. Niebel*, West Side VA Hospital, Chicago.

Thyroid carcinoma exhibit captures attention of John D. MacCarthy, M.D., pathologist, Sacred Heart Hospital, Spokane. Roger Gilbert, M.D., and William A. Hawk, M.D., Cleveland Clinic, answer questions.

Traces of Nickel in Smoke May Prove Carcinogenic

A high incidence of cancer of the respiratory system has been noted in industrial workers chronically exposed to inhalations of nickel carbonyl or nickel dust. For several years, our laboratory staff has studied the hazards of such exposures.

We recently reported the experimental induction of pulmonary cancers in rats subjected to 30-minute inhalations of nickel carbonyl in concentrations of four parts per million, three times weekly, for a period of one year. These neoplasms were not observed until two or more years after the initial exposure.

Results of study reveal that cigarette tobacco contains trace amounts of nickel. During burning, a portion of this nickel is released into the smoke. The amount of nickel subject to inhalation by heavy smokers is estimated to be of a magnitude which has been demonstrated carcinogenic for rats – a species notably resistant to the induction of pulmonary cancer. – *F. William Sunderman, M.D., and F. William Sunderman, Jr., M.D.*, Philadelphia.

Adrenal Hormones Linked To Sexual Maturation

Androgens are important secretory products of the adrenal cortex in normal and pathologic states, but little is actually known about their functional role. It has been suggested that they may inhibit the production of pituitary gonadotrophins.

In recent studies, we tested six newly available adrenal androgens in immature female mice, just after weaning. The animals were treated with daily subcutaneous injections of small graded doses of the hormones. The mice were then sacrificed after all the control animals manifested signs of sexual maturity.

Pituitary glands were collected for assay of gonadotrophin, and vaginal smears were prepared. Ovaries and uteri were weighed.

There was a delay shown in sexual maturation. No mature fol-

(*Continued on page 57*)

8 second magic in I.V. set-ups

remove metal seal and disc

plug set into center of stopper with a quick thrust

quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

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Medication can be added (aseptically) either before or after the flask has been suspended on the T stand, even after infusion is started.

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The rubber stopper is exposed and the set plugged in with one thrust. Then bottle is inverted to automatically establish a fluid level in drip chamber. Tubing is cleared of air. Takes about 8 seconds.

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I. V. "Y" Set-Up for Two Solutions

Hypodermoclysis Set-Up

Blood Tandem Set-Up

"Y" Set-Up for Blood and Solution

Israel Davidsohn, M.D., (l.), director of pathology, Mt. Sinai Hospital, Chicago, was presented with a Steuben bowl commemmorating his choice as "Pathologist of the Year" by Dr. Frank Coleman, CAP president. Dr. Davidsohn's over-all contributions to pathology, and particularly his technological advances, were responsible for his citation.

LAB

(*Continued from page* 54)

licles were observed in the ovaries of the treated animals, developing follicles were resorbed, and marked luteinization of these cells was evident. Uteri were atrophic, vaginal mucification was noted, and there was no evidence of estrus.

Although the preliminary nature of the studies must be emphasized, results tend to support the theory that certain adrenal hormones govern the secretion of pituitary gonadotrophins, which cause normal sexual maturation. Mild adrenal hyperfunction may bring about suppression of the secretion of gonadotrophins.

The studies may offer a possible explanation of why psychological or physical stress, known to increase secretion of the hormones, may in turn cause disruption in female reproductve processes. Even mild adrenal hyperfunction produced by such stress may be capable of causing sufficient imbalance so as to disrupt the normal menstrual cycle and inhibit ovulation.—*Harold H. Varon, M.D., and John J. Christian, M.D.,* Bethesda, Md.

Pulmonary Megakaryocytes Additional Platelet Source

The sudden development of thrombocythemia has hitherto defied explanation. In a recent series of studies, evidence was found that the megakaryocytes in pulmonary vessels may be a significant site of formation of platelets. We observed that pulmonary megakaryocytes are normally present in small numbers in the blood vessels of all animals studied to date and may be present in greatly increased numbers in certain disease states in humans, especially thromboembolism.

The megakaryocytes are transported regularly and normally by the blood from the bone marrow to the lung blood vessels, where they also break up to form platelets. This transportation has been observed to take place in humans beginning in early fetal life, and at all ages. Under certain conditions and disease states, larger numbers have been noted to be transported.

Under various stress conditions, the megakaryocytes were noticed to break up suddenly and more rapidly into platelets.

The degree of thrombocythemia, and its demonstrated associated blood hypercoagulability, seems to depend on the number of megakaryocytes that enter and break up in the pulmonary vascular tree at any given time.

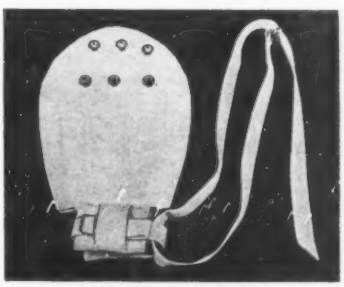
In an attempt to confirm our observation in humans, after observing the association in rabbits, we studied 41 major surgical patients. The patients were unselected, inasmuch as the lungs of most postoperative patients were noted to contain an increased number of megakaryocytes and also had the

(*Continued on page* 85)

For Patient Protection

The Posey Safety Belt
Prevents patients falling out of bed. Cat. #S-141, $6.45. (Extra heavy construction with key-lock buckles. Cat. #P-453, $19.50 each.)

The Posey "V" Restraint
A good all-purpose restraint to prevent patients from falling or getting out of bed. Particularly good for use on females as it does not irritate busts. Available in Small, Medium, and Large sizes. Posey "V" Restraint Cat. No. V-958. Price $6.90 each.



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For further information see postcard opposite page 126.

Sister-Technologist Wins National Contest With Life-Saving Story

The story of a telephone call won an all-expense paid trip to the American Association of Blood Banks meeting in San Francisco for Sister Moira, blood-bank technologist of Bismarck, N. Dak.

The Sister's phone call was placed because of the desperate need for Type A, Rh-negative blood. The name of a garage mechanic in Bismarck was listed in the blood-bank file as having the rare blood type. When the hospital's call reached the garage, the mechanic could not be found. Sister Moira insisted that the donor be located and report to the hospital immediately.

Sister Moira

Some time later, the man appeared at the hospital laboratory. He was unable to give blood, but came to thank Sister Moira for her call. When employees at the garage had continued to search for him at the Sister's urging, he had been found under a car unconscious from carbon monoxide poisoning. The technologist's persistence had saved his life.

Sister Moira's story was one of hundreds submitted by technologists in the U.S. and Canada in a contest sponsored by Fenwal Laboratories, Inc., Framingham, Mass. Each entrant was asked to write about the one moment in his blood-bank career that stood out as most important.

Sister Moira directs blood banks at St. Alexius Hospital, Bismarck, and Memorial Hospital, Garrison. Her San Francisco flight was the occasion of her first plane trip. During her stay in the west coast city, she was accorded a reception by the mayor, George Christopher, and visited the city's points of interest.

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The Pharmacist's Role in Poison Control Centers

By Joseph R. Christian, M.D.*

Since its initiation in 1954, the participants in the Chicago Poison Control Center have developed operational plans most feasible for their specific areas. Some centers function as a part of an emergency service of a general hospital, others utilize the local health department, still others originate as a part of the pediatrics department of a medical school or a service of the county medical society. Overlooked—to a certain extent—is the role the hospital pharmacist might assume.

In setting up a method to operate a center, several factors must be considered: the geographic area to be served, the total populations, the available personnel; the most suitable plan for the specific area should be utilized. But one plan which seems to be feasible and practical in most areas is to designate the hospital pharmacist as the poison control officer.

A statistical breakdown of types of substances reported in accidental poisonings in Chicago in 1959 shows that in 56 percent of the cases the substance was some type of medication (see Table I). These medications are substances with which the pharmacist is more familiar than the other hospital personnel. He should, therefore, be of invaluable service to both the physician and the patient.

In any case of accidental poisoning, the most pressing problem is to know the following:

1. Degree of toxicity of substance ingested.
2. Amount of toxic substance ingested.
3. Length of time since ingestion of toxic substance.
4. Abnormal signs or symptoms due to ingestion of poisonous substances.
5. Emergency treatment.
6. Ultimate treatment.
7. Prognosis.

Of course, the last three points listed above should be managed by a physician. The first four points, however, can be handled by a paramedical person.

The pharmaceutical companies, paint industry, petroleum industry, cosmetic industry, and others, have been extremely cooperative with poison control centers in supplying all the information necessary about their products. Periodic booklets, cards, brochures, are submitted to the centers as they are available. This material contains information about specific drugs or preparations with toxic constituents, abnormal signs and symptoms, pathologic changes, emergency treatment, and so on.

By collecting this data and setting up a file index, a rich source of information can be made available in a short period of time. In spite of continuous contact with the treatment of accidental poisoning, it is impossible to recall specific information that is accurate — it is far safer to rely upon accurate data from an information file.

At present, there are 11 centers functioning in the Chicago area. These hospitals act as treatment and information centers. In addition, all hospitals with emergency-room facilities within the city of Chicago have been instructed to have supplies and materials available so that any case of accidental poisoning can be given emergency care.

The poison information, treatment, and referral center in Chicago has been located at Mercy Hospital since the initiation of the poison control program. A 24-hour information service for physicians and hospitals is available through the pediatric department of Mercy. Through the present setup, all poison control calls are transferred to pediatrics, and an assigned resident obtains accurate and detailed information within minutes, so that any patient accidentally ingesting a poisonous substance may receive the best possible therapy.

However, as stressed before, any procedure other than the actual treatment and prognosis could, perhaps, be more readily handled by the pharmacist.

The idea of a poison control

(Continued on next page)

*Professor, department of pediatrics, Stritch School of Medicine, Loyola University, and chairman, department of pediatrics, Mercy Hospital, Chicago.

center originated in 1950 when the Accident Prevention Committee was appointed by the American Academy of Pediatrics as a result of growing concern over the ever-increasing problem of accidental deaths in infancy and childhood.

In 1953, the first formal meeting of the poison control committee of the Illinois chapter of the American Academy of Pediatrics was held. This committee consisted of the chairmen of the department of pediatrics of each of the five medical schools in Chicago, the chairman of the department of pediatrics of a large general hospital, the state chairman of the American Academy of Pediatrics, and representatives of the Chicago Board of Health, the state toxicological laboratory, the American Medical Association, the Federal Food and Drug Administration, and the National Safety Council.

Six hospitals participated originally. A poison control officer and an alternate were appointed for each of these hospitals. This designated officer was responsible for instructing the professional personnel concerning the management of poison cases; for having reference books and manuals available for use by members of the staff; for giving specific advice to the house staff or to staff physicians concerning poison cases; and for reporting all cases to the poison control center at the Chicago Board of Health.

No specific therapy was recommended. Each poison control officer was free to use his own judgment, but each case, treated or untreated, was reported to the center at the Board of Health. The reports were then analyzed and summarized by members of the poison control committee and later tabulated to obtain as much useful information as possible.

To prevent recurrence of the specific accidental poisoning reported, the Chicago Board of Health visiting nurses made home visits. Evaluation of the home was made with respect to safety, existing conditions, and general health. A second follow-up report form was completed by the visiting public health nurse and returned to the center for statistical analysis.

The program was officially endorsed by the Chicago Medical Society and the Chicago Pediatrics Society in 1954; subsequently, all Chicago hospitals were invited to participate.

By the end of 1955, 14 cities had centers in actual operation, and nine additional cities had centers at various stages of development. Each, of course, had organizational plans most suitable for the specific area and situation.

All centers record and tabulate the numbers and types of poisonings and offer facilities for emergency treatment through either the center itself or one of the local participating hospitals. By means of these records, current information is made available concerning the toxic constituents of pharmaceuticals and household products as well as suggestions or recommendations for specific treatment.

In 1957, two additions to the plan took place. One was the sending of a duplicate treatment report to the division of preventive medicine, Department of Public Health of the state of Illinois. A follow-up form was then sent to the regional health officer for investigation.

In the second change, plans were formulated to establish a national clearinghouse for poison control centers within the Accident Prevention Bureau, Division of Special Health Services, Bureau of State Services. The clearinghouse has five purposes:

1. Interchange of information with local poison control centers throughout the country.

2. Stimulation of development of new or improved methods of prevention and treatment of poison cases, and encouragement of basic and clinical research.

3. Aid to states and local communities in establishing poison control centers.

4. Study of national and area trends in poisoning and successful methods of prevention and treatment; preparation of news releases for professional and lay health education.

5. Repository of information voluntarily provided by manufacturers.

Since 1950, when the accident prevention committee was first appointed, numerous methods for the operation of poison control centers have been proposed. Now, after six years of operation, the pharmacist's role should be reconsidered. With regard to each specific situation, the pharmacist is often the logical one to designate as the poison control officer.

TABLE I
Reported Cases of Accidental Poisoning, Chicago, 1959

I. Type of Substance

Medications	2,289
Household preparations	665
Petroleum distillates	150
Pesticides, insecticides	309
Paint, lacquers, solvents	188
Cosmetics	87
Gases, vapors	47
Plants	14
All other substances	118
Unknown substances	163
Combinations	5
Total	4,035

II. Reported Cases According to Age

Age unknown	41
Under 1 year	135
1 year old	1,014
2 years	1,145
3 years	555
4 years	177
5-9 years	110
10-12 years	19
13-14 years	16
15-19 years	92
20 years or more	731

III. Fatalities of reported cases

Medications	12
Household preparations	1
Pesticides	1
Gases, vapors	1
Paint	12
Solvents	1
Unknown	7
Total	35

TABLE II
Antidote Supplies Essential For the Emergency Room

A. For unknown poisons: the universal antidote:

Activated powdered charcoal (burned toast)	2 parts
Magnesium oxide (milk of magnesia)	1 part
Tannic acid (strong tea)	1 part

B. Home remedies for the following substances

1. *Iodine*: flour or starch.
2. *Alkaloids*, such as atropine or morphine: strong tea, dilute tincture of iodine solution (15 drops in ½ glass of water), or weak tannic acid.
3. *Heavy metals*: milk and eggs to provide protein to precipitate the poison.
4. *Central nervous system depressants*: (i.e., barbituates, or alcohol)—strong coffee or tea for stimulation.
5. *Corrosives*: oils.
6. *Acids*: Sodium bicarbonate, milk of magnesia, chalk, soap and water.
7. *Alkali*: lemon water or citrus fruit juice, vinegar.

C. Specific Medications

1. ACTH
2. Alcohol, ethyl
3. Aminophylline for intramuscular and intravenous use
4. Amyl nitrite perles
5. Animal charcoal (to prepare universal antidote)
6. Aromatic spirits of ammonia
7. Atropine sulfate
8. BAL in oil
9. Caffeine sodium benzoate for intravenous use
10. Calcium gluconate 10% for intravenous use
11. Calcium disodium edathamil
12. Chloral hydrate
13. Chloroform
14. Cortisone
15. Dextrose in water 50% for intravenous use (20-cc. vials)
16. Digitalis preparations for intravenous and intramuscular use
17. Ephedrine sulfate for oral use
18. Epinephrine 1:1000
19. Ether
20. Hydrochloric acid 0.5% or vinegar 1:4
21. Hydrocortisone
22. Magnesium oxide (to prepare universal antidote)
23. Magnesium sulfate 50% solution for intravenous use
24. Megimide
25. Metacorten
26. Methylene blue 1% 50-cc ampules
27. Metrazol 25% solution
28. Nalline
29. Nor-epinephrine
30. Oxygen
31. Paraldehyde
32. Pentobarbital (Nembutal)
33. Pentothal sodium for intravenous use
34. Picrotoxin
35. Plasma, lyophilized and irradiated
36. Potassium permanganate, 3 gr.
37. Prostigmine methylsulfate 1:2000, 1:4000
38. Sodium amytal for intravenous use
39. Sodium bicarbonate
40. Sodium chloride (physiologic) solution
41. Sodium formaldehyde sulfoxalate, 10 gm. (Make 5-10% solution; freshly made is excellent for lavage in mercury poisoning. Use 250 cc. for lavage and leave 100-200 cc. in stomach after lavage.)
42. Sodium thiosulfate, 10%
43. Starch
44. Tannic acid (to prepare universal antidote)

D. Supplies

1. Catheters and stomach tubes of various sizes
2. Syringes: 50-cc, 20-cc, 10-cc, 5-cc, and 2-cc
3. Needles; hypo and intravenous
4. Mouth gag
5. Restraint sheets, blankets
6. Emesis basins
7. Containers for storage of aspirated gastric contents
8. Poison Report forms
9. Reference material:
   a) *Physician's Desk Reference.*
   b) Nelson's *Textbook of Pediatrics* (sixth edition).
   c) DeSanctis and Varga's *Handbook of Pediatric Medical Emergencies* (second edition).
   d) Dreisbach's *Handbook of Poisons* (Lange Medical Publications, Los Altos, Calif.).
   e) Press's *Accidental Poisoning in Children* (American Academy of Pediatrics).
   f) Goodman and Gilman's *Textbook of Pharmacology.*
   g) Gleason, Gosselin, and Hodge, *Clinical Toxicology of Commercial Poisons* (Williams and Wilkins).

E. Desirable Equipment

1. Tracheotomy set
2. Suction machine
3. Resuscitator
4. Laryngoscope and endotracheal tubes
5. Thoracotomy tray
6. Spinal tray

prescription pad

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ColBenemid, a combination of benemid and colchicine for treatment of gout and gouty arthritis is a new product of Merck Sharp & Dohme.

Available in bottles of 100, each tablet contains 0.5 mg. of probenecid and 0.5 mg. of colchicine.

For Schistosomiasis

Lucanthone, a drug for treatment of schistosomiasis which may be given by mouth, has been announced by Burroughs Wellcome & Co., Inc. A synthetic thioxanthone derivative, it is recommended for cases of S. mansoni and S. hematobium infections.

Tablets contain 200 mg. of Lucanthone hydrochloride and are supplied in bottles of 30.

For Sodium Retention

Geigy Pharmaceuticals has recently released Hygroton, a drug for relief of arterial hypertension and edema associated with sodium retention.

For Dysmenorrhea

Valoctin is recommended by Knoll Pharmaceutical Co. for relief of dysmenorrhea. A combination of methylisooctenylamine (octin) and monobromisovalerylcarbamide (bromural), the tablets are available in bottles of 100.

New Ophthalmic Gel

Schieffelin & Co. has developed Cyclobar, an ophthalmic gel for use before and after ocular surgery, and for treatment of ocular infections, and injured eyes. Cyclobar is a combination of Cyclogyl, Schieffelin's cycloplegic and mydriatic agent, and neomycin. Supplied in 3.54 gm. collapsible tubes.

new... ..mouth-fitting nipple helps prevent excessive air swallowing

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Clinically proved with both normal and hard-to-feed babies, lasts twice as long as ordinary nipples. Available in complete "Sure-Grip" nurser. Contoured CURITY bottle provides exceptionally firm grip. Square shape stores better.

Ordinary, bell-shaped nipple lets air in at corners. Often collapses and pinches shut. Ordinary nipple requires "push-pull" action to start feeding and insertion is often too deep for newborn. Rubber is frequently too tough to permit easy sucking action.

Oval-shaped Rib Nipple helps seal out air. Hollow ribs assure flow, won't bite shut. The Rib Nipple allows gentle "twist action" to start feeding for newborn. Premies take more formula. Less burping, less colic. Rubber is soft, yet withstands repeated washing.

Special help for common problems. Sluggish eaters get a full feeding with less effort through the Rib Nipple. With the prompting of "twist action", premies take and hold more. And cleft palate feeding is seldom a problem.

Improves normal feeding action. With the Rib Nipple, the baby doesn't eat too fast. Less spitting up. Supplementary feedings for the breast-fed are easier. The soft, functional shape allows smoother feeding with new as well as older babies.

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For further information see postcard opposite page 126.

Pediatrics

"A Sick Child Is, First of All, a Child . . . "

A child, one of the most flawless mirrors fashioned by nature, reflects what he sees, feels, and experiences. Loved, he is responsive; secure, he is confident; wanted, he is outgoing. In health, he is active. In illness, the mirror may become filmed, the image distorted. Still it reflects, to the trained eye, the impact of the primary impression. Emotionally stable, he is generally cooperative. Frightened, lonely, or in pain beyond his comprehension, he may be withdrawn or hostile.

Medicine in this country has made such enormous strides, and is generally practiced on such a high level, that treating the total patient is no longer a new concept. The Children's Hospital, in Cincinnati, Ohio, has always recognized that a child, whether sick or well, is first of all a child, not a smaller version of an adult.

The body, physically; the heart as the reservoir of emotions; and the mind as the stimuli for thought, growth, and action, have been interlocked in the hospital's philosophy since it was founded in 1883 by a handful of Episcopal churchwomen. But it has been within the past 30 years that new drugs, new types of treatments, and new surgical procedures have so changed medicine that physicians and nurses have been able to come closer to their ideal of devoting their efforts to the entire child.

"The story of hospital care of children," said A. Ashley Weech, M.D., chief-of-staff and director of the Research Foundation of the hospital since 1942, "goes back to the early civilizations of Egypt, Greece, India, Ireland, Siam, and Persia, where there is evidence that hospitals not only existed but admitted children as well as adults.

"With the rise of Christianity in the fourth century, public hospitals were organized, and we find records of foundling homes and asylums for children. For many centuries, these institutions suffered from lack of medical knowledge, low standards of hygiene, inadequate nursing, insufficient funds and seemingly from lack of concern for the lives of children. Mortalities brushed close to 100 percent.

"The first modern hospital for the care of sick

(*Continued on next page*)

"Doc," a brown rabbit, who has his own house in a corner of one of the playrooms, comes out occasionally to visit with one of the patients. His warm, furry body fills a need this youngster couldn't put into words, but which lies deep within him. The playrooms also have live birds and goldfish; for the smallest ones, there are toy birds to flutter from the crib rails.

Famous personalities are frequent visitors, and performers, at the hospital. Here gun-toting Wyatt Earp (Hugh O'Brian) and Virginia M. Caldwell, administrative assistant at Children's, chat with radio-TV's Ruth Lyons (Mrs. Herman Newman), Lady Bountiful to youngsters in 36 hospitals, and one of Children's Hospital's most cherished "volunteers." Standing back of Miss Lyons is her daughter, Candy.

children," continued Dr. Weech, "was established in Paris, France, in 1802. It operated on the principle that sick children should be separated from adults, and that each child should have his own bed. Philadelphia Children's Hospital, which opened in 1855, was the first children's hospital in this country. In March, 1884, the Cincinnati Children's Hospital opened its doors; in December of 1926, the present building was dedicated."

Primarily a private institution, the hospital is administered from the Southern Ohio Diocese of the Protestant Episcopal Church. Medically, it is under the department of pediatrics of the University of Cincinnati College of Medicine. Of the city's four big private hospitals, two have small pediatrics departments, the other two, none; so in effect, The Children's Hospital provides most of the pediatrics service for this area.

With 215 beds, the hospital totals over 9,200 admissions a year, drawing its patients from southwestern Ohio, Kentucky, and eastern Indiana; there are 25,000 visits to its outpatient department each year. The latter represent selected patients, many of them presenting exotic symptoms and illnesses, for whom something constructive can be accomplished. Patients range from the newborn to 16 years. There is every clinical service at the hospital with the exception of obstetrics and geriatrics.

There are 26 resident doctors in training at the hospital; the attending staff number 203; the courtesy staff, 104. There is a staff of 13 fulltime research investigators, many of whose names illuminate the records of research achievements of the world.

Fifteen schools of nursing, from Davenport, Iowa, to Charlestown, W. Va., send their students to it for their pediatric affiliation. Five other hospitals in Cincinnati rotate their nurses and internes through it.

Operating rooms are five in number; there are two centers for youngsters under one year; two for toddlers; two for older children and two of private rooms. When TOPICS' reporter visited the hospital, plans for an experimental adolescent unit were just getting under way.

We commented on the unusual number of adults, non-professional, that we passed in the halls. "Those that aren't volunteers," explained Mr. Southwick, "are parents. Visiting hours here are practically unlimited. Neither a child, nor a parent, can contain the need for each other to given hours, and in the private areas we insist on the presence of the mothers as a vital part of the over-all therapy. The private rooms are furnished with a comfortable cot for the mother, and a crib for the child, and regular meals for parents are obtainable at the coffee shop.

"It isn't exactly unheard of, even in these days," continued Mr. Southwick, "to hear a nurse in a general hospital express the personal opinion that if she could just get an overprotective and excitable mother out from underfoot, she would have a much more tractable patient. In some cases that's true, but we feel that when it is a fact, the mother needs help almost as much as the child does — and that in all cases, the child needs the mother. He needs a father, too, and if he has none, as was the way with six-year-old Billy Hacker, we find a substitute.

"Billy's physical illness was diagnosed as tuberculosis of the spine, which meant nearly absolute immobility on a Bradford frame until an operation could be performed. His emotional state was explored by the nurse, the teacher, the recreation worker, the psychologist, and the social worker, who reported on his silence, his passiveness, his apparently good intelligence masked by infantile habits and speech. Together they interpreted his actions as resulting from his complete dependence on his widowed mother, who had to work, his loneliness away from her, and the need for a man in his life.

"A young medical student agreed to visit Billy every night. He played games with him, became his

friend, and subbed for the missing father. The nurse took him on tours of the hospital every day to get him acquainted with other patients. But he was still too good, too quiet. The most welcome sound he ever made came one morning when he turned his toy gun on everyone within range, happily killing off his enemies in a fantasy that relieved his pent-up emotions. That was the turning point for Billy. After several months, he underwent orthopedic surgery. When he was finally discharged, the change in the boy was dramatic. Not only was he physically able to enjoy a normal life, but he had a new outlook, and he was a happy, well-adjusted boy.

"This almost total change in Billy," concluded Mr. Southwick, "could not have been brought about by medicine and surgery alone. It was the sum total of the efforts of everyone who had any contact with Billy."

"I tell this story because it has been made into a movie. It is the story of The Children's Hospital — and the happiness, fears and hopes of thousands of little children and their parents. It is called 'The Whole Child', dozens of copies of it have been made and it has been shown or televised all over the world."

The Co-operative Society of Children's Hospital was founded when the institution was granted its charter in 1883, and was originally limited to women of the Episcopal Church. Through the years, augmented by the efforts of women of many sects, it has grown in numbers and activities.

During 1959, about 3,500 people contributed 31,600 hours of volunteer work. One woman has spent a total of 3,500 hours telling stories to the youngsters. Another group of volunteers prepared 30,000 medical records for microfilming.

Other volunteers work with the children in nursing, recreation, admitting and the out-patient clinic, and a group from the University of Cincinnati Teacher's College help in recreation as part of the teacher-training program.

There are no hospital gowns or robes in evidence among the ambulatory patients. One of the highlights of the youngsters' day is the time spent before the racks of starched and pressed clothes, in delicious indecision over what to wear. They are given complete freedom of choice—provided it fits—and some of the color combinations charm the wearers though they may cause the adults to blink.

The setting is different, but the theme's the same. A mother stands by to make sure her son takes care of the vegetables on his luncheon tray before he tackles the dessert. Visiting hours are practically unlimited at the hospital; in the private rooms, the hospital insists that the mother stay with her child as part of the over-all therapy. A comfortable cot is provided in the room, and meals are available in the coffee shop.

One of the most cherished of "volunteers" is Ruth Lyons, a midwest radio-TV phenomenon whose 50-50 Club originates at Cincinnati's WLW daily from noon to 1:30 p.m. A participating program, Miss Lyons has a 15-year waiting list of sponsors, and an audience of 75,000 women. Impressive as the statistics are, Miss Lyons' effect on her audience is little short of fabulous. Her wish is their command. That her wish is to help hospitalized youngsters has meant a great deal of happiness and accelerated recoveries to children in 36 hospitals that participate in the Ruth Lyons' fund. Audiences, responsive to her dynamic personality and genuine dedicated interest in sick youngsters, have kept a steady stream of contributions flowing into the 50-50 Club coffers.

Though the figures cannot be released for publication, the extras that Children's Hospital is able to give its patients will give an idea of the magnitude of Miss Lyons' project.

In one corner of a playroom is a smaller room called the Ruth Lyons Magic Cupboard, rich as plum pud-

(Continued on next page)

Youngsters gather around tables for playtime and mealtime, enjoying the companionship of each other and trained adults. On the left, toddlers make believe with toys of their own choosing.

Below, older children divide their attention between luncheon and Topics' photographer. A family atmosphere is maintained, and youngsters serve themselves as they would at home.

ding and chock-full as a Christmas stocking. Even to adult eyes, it *is* Christmas—the kind kids dream about. Every toy in the cupboard sparkles with newness, and even the inexperienced eye needs no visible price tags to know that these are the best of their kind. The dolls, many of them, are lifesized, and elegantly dressed. Boys' toys have precision engines. Even the pull-toys for toddlers are beautifully designed and crafted.

Each child admitted to the hospital selects a gift from the Magic Cupboard, either on admission or when he is well enough to make the trip.

The adjacent play area, with a colored tile fishpond, and across the room is a newcomer named "Doc" money given by the fund. There are big dollhouses, completely furnished. These afforded considerable overdue pleasure to a visiting adult remembering the painted-on drawers and glued-to-the-floor furniture of childhood dollhouses.

Fat goldfish are permanent residents in the fishpond, and across the room is a newcomer named "Doc" —"in honor of everybody," explained Mrs. Patricia Hehner, recreational therapist who heads a staff of five professionals who direct play activities for all ambulatory patients. "Doc," a brown rabbit, was at the moment out of the house built for him by a hospital carpenter and nestled in the arms of a small boy wearing a Cincinnati Redlegs jacket.

"It's a little warm for that jacket today," commented Mrs. Hehner, "but it's brand new, and it's what Jimmy wanted more than anything else in the world. We don't know how long Jimmy will be here, but we do know that he will never go home, so we let him wear it. This is the sort of thing the hospital couldn't afford if it weren't for Ruth Lyons," she added.

The Baldwin piano, also a gift, has been played by some of the top names in the country. "We get lots of entertainers who stop here on their way through town," said Mrs. Hehner. "Wyatt Earp was here several weeks ago. Roy Rogers came recently, and brought his horse. We had a magician, too, about the same time, only he didn't bring his rabbit. I called the research laboratory and they said, sure, they'd lend us a rabbit for the magician to pull out of his hat. They sent over the biggest white buck I ever laid my eyes on. When the lab messenger dropped him into the magician's arms, I thought the two of them were going to go through the floor. He did a lot of other tricks, though, and 'Doc' will fit into a hat fine, in case another magician comes along before too long."

A young child whose harelip would have been a lifelong handicap not too many years ago, is recovering from corrective surgery. Accomplishments of the hospital's Research Foundation on congenital malformations are dramatic and impressive.

Youngsters not well enough to go to the playrooms have the playroom brought to them by the staff of student nurses and volunteers. Finger painting is popular, toddlers love the pull-toys and wooden clowns, and for the smallest ones there are toy birds and butterflies to flutter over their cribs and a soft toy to cuddle. All these things, and many more, are from the Ruth Lyons' fund.

Ambulatory youngsters, and those who can be wheeled into the playrooms, eat family style and serve themselves if possible. Every Wednesday night there is a Get Well Club, which starts off with a dress-up dinner and the members plan their menu. Every holiday, of course, is a big day, topped by the Christmas festivities.

Last year, 50 children who had had open heart surgery at the hospital, together with their parents, came back to Children's Hospital for a "Happy Hearts Homecoming" during National Hospital Week. Fun included a picnic with young Hawaiian dancers, a trip to the zoo, Frisch's Mainliner, Coney Island, sightseeing, and a grand banquet. At the end of the two days, parents and staff were exhausted, but the hearts of the former patients were still going strong.

Back of all this heart and warmth are some of the finest minds currently engaged in medical research. Many of them are unknown outside professional circles, though in their own field they are well known and deeply respected.

The Research Foundation was begun in 1926, with an endowment from William Cooper Procter, one of the founders of Procter & Gamble. Currently, grants from the government, the National Foundation, and other sources have augmented this endowment.

"The Research Foundation," said Dr. Weech, "ranks among the world's leaders in the study of the causes and treatment of childhood diseases. The studies being done of Dr. Josef Warkany and a group of investigators on congenital malformations such as harelip, cleft palate, and club foot, are dramatic and enormously important, though not generally known to the public. Congenital malformations in hybrid rats and inbred strains of mice are being produced during gestation by a riboflavin-deficient diet, by toxic doses of salicylates, and by large doses of vitamin A at various times during the middle part of pregnancies.

"Two factors were discovered that modify the incidence of cortisone-induced cleft palate. The first is a seasonal one, many more defectives occurring

The girls above, with one of the mothers siting in, are making cut-out rabbits of heavy colored paper. The completed bunnies were used to decorate areas for the Easter holidays.

Sitting on the TV set is the working model fashioned by the instructor. This young lady is one of the volunteers from the University of Cincinnati Teacher's College.

during the winter months than during the summer months. The second, which increases the frequency of cortisone-induced palate, is underfeeding pregnant mice during the time cortisone is administered.

"The studies of diabetes in children by Dr. G. M. Guest, of the physiology and biochemistry department, resulted in his being made a member of the Legion of Honor of France. Long-range studies of the development and standardization of dysentery vaccines have been made under the direction of Dr. Merlin L. Cooper, head of the bacteriology department. The intensive studies of this department on infections at the time of admission among patients due to pathogenic types of staphylococci, and the work in progress to determine the prevalence of carriers among patients and personnel of these 'bugs' will soon be presented in a very significant paper by Dr. Cooper.

"The studies of Dr. Benjamin H. Landing, director of pediatric pathology and his associates of the anti-thyroid antibody in relation to congenital diseases are also significant. Sera of mothers of cretin babies who have anti-thyroid antibody were tested on thyroid cells in tissue culture and found to be cytotoxic. This antibody has been demonstrated in the blood of the newborn infant, and apparently causes cretinism by damaging the fetal thyroid in utero.

"Cardiology, of course, has made enormous progress, and this department has long since developed a heart-lung machine which has permitted surgical correction of defects so situated in the heart that they are not directly visual by any means now in use.

"The work of Albert B. Sabin, M.D., on virus diseases is, of course, known even to great numbers of lay persons in various parts of the world, not only because of the drama inherent in it, but because of field trials with live poliovirus vaccine."

Last year, field trials were completed in the U.S.S.R., Czechoslavakia (140,000), Singapore (200,000), and Mexico (200,000). The tests in Russia, where 70,000 children received Dr. Sabin's original vaccine, and about 12 million were fed vaccine prepared by the Russians from his original lots, provided the most definitive evidence of the safety of the vaccine for those who received it as well as for those who became immunized on contact infection.

Results in Mexico indicated that in subtropical and tropical countries in populations of poor sanitation and hygiene, the usual natural high incidence of polio-viruses and other enteric viruses partially interfered with the maximum effectiveness of the live poliovirus vaccine and that special methods of mass applications within the shortest possible time would have to be investigated.

Additionally, Dr. Sabin is continuing research with Echo and Coxsackie viruses, certain viruses associated with respiratory disease, the "Reoviruses," a new group of respiratory-enteric viruses formerly Echo Type 10, and the development of "Cold" mutants of polioviruses.

This spring, through a joint, co-operative effort by doctors, hospitals, schools and Health Department, Sabin Oral vaccine was given to 180,000 children of Cincinnati.

"I am sure," concluded Dr. Weech, "that the fact that we are a teaching institution, as well as a research foundation, has a great deal to do with the accomplishments at Children's Hospital.

"Classroom instruction and bedside instruction and observation go on continually. Students are senior medical students, internes and residents, graduate and student nurses; dietitians; and graduate students and fellows learning the technics of research. Teachers are all of the graduate nurses and dietitians and the members of the full-time medical and research staff, and practicing community pediatricians.

"The chief teaches the seniors, the seniors teach the juniors, the juniors teach the internes—and in a very real way, all teach one another. In this climate of mutual giving and receiving, the professionals achieve a rounded, balanced education, and the children are brought back to health as individuals — not alone as patients."

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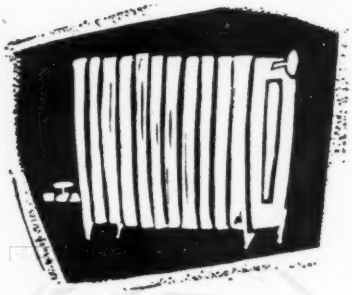

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Restoring Bowel Function in the Postpartum Patient

Time appears to be the main factor that promotes a restoration of physiologic bowel function in the postpartum patient, regardless of what is used as a laxative medication, Frederick P. Zuspan, M.D., concluded after a study of postpartum bowel function was carried out on 244 patients.

Dr. Zuspan's report appears in the September, 1960 issue of the *American Journal of Obstetrics and Gynecology*.

In the double-blind study, 121 patients at the McDowell (Ky.) Memorial Hospital received placebo capsules and 123 patients received laxative capsules – each of which contained 50 mg. of dioctyl sodium succinate and the standardized senna concentrate of active principles of 225 mg. of *Cassia acutifolia* pods.

No apparent difference in effect was seen between the placebo and the laxative medication. In both groups it was approximately 2½ days after delivery before the first bowel movement occurred.

Primiparous patients requested more enemas than did multiparous patients. Dr. Zuspan suggests two possible reasons: the large episiotomy with accompanying discomfort and fear of having a bowel movement, and longer labors with associated relatively greater dehydration.

Lactating patients requested more enemas than did the over-all group or the nonlactating patients. Though the reason is not obvious, Dr. Zuspan believes it may be the relative degree of dehydration associated with nursing. He suggests also that the increased excretion of antidiuretic hormone elaborated during nursing may play a role in regulating the thirst mechanism.

Several factors, he points out, often combine to make the re-establishment of bowel regularity somewhat delayed. The motility of the intestinal tract diminishes during pregnancy, and normal delivery is often followed by a mild passing episode of ileus. The patient has frequently had a cleansing enema and has missed one to four meals during labor. Furthermore, the puerperal diuresis may make less fluid available to the intestinal tract.

Physicians and nurses should attempt to relieve patients' anxiety about irregularity, he advises. Ambulation, adequate hydration, and control of episiotomy discomfort may promote return of normal bowel function. The postpartum enema, says Dr. Zuspan, should be reserved for the patients who need and request it.

Eliminating Thrush from the Nursery

A simple, inexpensive procedure to eliminate thrush from hospital nurseries is described by L. J. Harris, M.D., the New Mount Sinai Hospital, Toronto, Ont., Canada, in an article in the July, 1960, issue of the *American Journal of Obstetrics and Gynecology*.

The procedure calls for each infant to receive two instillations of nystatin – each instillation consisting of 1 cc. or 100,000 units of nystatin in suspension – by means of an eyedropper into the oral cavity. Administration of one instillation on the second day and one on the fifth day will prevent thrush in all babies in the nursery, Dr. Harris has concluded on the basis of results with use of the treatment at his hospital.

Thrush, caused by the fungus *Candida* or *Monilia albicans*, occurs in about four percent of all newborn infants in the first week of life. Though it is usually mild, it may spread to the gastrointestinal

(Continued on next page)

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tract and perianal region, and occasionally to the tracea, bronchi, and lungs, leading to serious illness and perhaps even death.

In any event, Dr. Harris comments, it is a source of annoyance, and the mothers of affected infants usually blame it on poor nursing or medical care, although studies have shown a high correlation between the appearance of thrush in the infant and the presence of *C. albicans* in the vagina of the mother.

Believing that a simple, safe, inexpensive procedure to eradicate thrush from hospital nurseries would be almost as great a boon as the eradication of ophthalmia neonatorum by the use of silver nitrate, the departments of obstetrics, pediatrics, and bacteriology at the New Mount Sinai Hospital undertook a study to learn the causes of *C. albicans* infections in infants, and to determine whether the condition could be eradicated by administration of a nystatin suspension.

In the study, which began in 1957, 4,243 infants were investigated. In the first series, 1,500 consecutive newborn infants were placed alternately in two groups of 750 each. Infants in the first group received daily instillations of 100,000 units of nystatin in suspension; infants in the control group received no treatment.

Of the 750 treated with nystatin, none developed thrush in the hospital, and only three developed it within one week after discharge. Among the control group, however, there were 31 cases — an incidence of four percent.

When the number of instillations was reduced to two — one on the second and one on the fifth day — there was no thrush in 1,000 consecutive babies. When the instillations were further reduced to only one, given on the third day of life, there were four cases of thrush in 1,560 babies. Of these four, two were weak prematures, one was a critically ill baby, and one was an apparently normal child. The investigators concluded that two instillations should be used.

Cost of the medication to the hospital is less than five cents per child. There have been no side-effects or complications from this treatment. No resistant strains of *C. albicans* have developed in the series, and repeated attempts to produce resistant strains of this organism in the laboratory have failed.

Effect on Infants of Administering Oxygen to Mothers in Labor

What effect does the administration of oxygen to mothers in labor have on their infants? The answer to this question is being sought in a continuing study by investigators at the University of Illinois College of Medicine.

Oxygen is administered at a rate of 10 L. per minute through a BLB mask to women in labor. The BLB mask was chosen because it fitted most patients better than other types of "demand masks."

Babies born of mothers who receive oxygen for more than 10 minutes prior to delivery have a con-

siderable increase in available oxygen compared to babies of mothers who receive no oxygen, report James H. McClure, M.D., and Joseph M. James in the September, 1960, issue of the *American Journal of Obstetrics and Gynecology*.

Although an increase in oxygen available to the fetus may be lifesaving in certain pathological conditions, whether or not oxygen administration is beneficial during a "normal" labor cannot be determined before analysis is made of the clinical outcome in a large series of infants from mothers who have been treated with oxygen, Dr. McClure believes.

Investigators Challenge Theory That Infant Takes Mother's B_{12}

Though the theory has been held that the fetus parasitizes the mother's vitamin B_{12} stores, studies by three investigators from the departments of pediatrics and obstetrics, New York Medical College, indicate that this is not true.

This theory has been based primarily upon the finding that serum vitamin B_{12} levels in pregnancy fall toward the last trimester to values approaching those found in pernicious anemia, whereas infant cord blood levels are considerably higher than corresponding maternal values.

Jack M. Cooperman, Ph.D., Alvin M. Donnenfeld, M.D., and Julia M. Herrero found, however, that newborn tissue concentrations of vitamin B_{12} were much lower than were those in corresponding maternal tissue. Fetal vitamin B_{12} is derived from maternal serum B_{12}, which appears under normal conditions to come chiefly from dietary sources rather than the maternal tissues, the scientists told the fifth International Congress on Nutrition.

Studies in the last month of pregnancy indicated a lowered gastrointestinal absorption of physiologic doses of $Co^{58}B_{12}$. Transfer of $Co^{58}B_{12}$ to the fetus occurred only when it was in the maternal blood.

They say that the decreasing maternal vitamin B_{12} serum levels during pregnancy may thus be accounted for by a combination of decreased gastrointestinal absorption and by partition of the incoming vitamin B_{12} to the placenta and fetus in addition to the mother's tissues.

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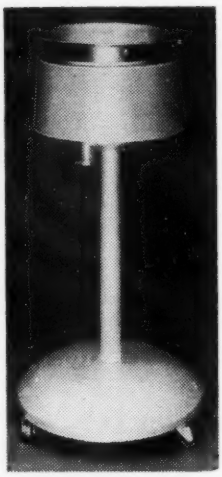

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(Continued from page 23)

others discussed in that it does not require an arbitrary classification of the area's role as rural, intermediate or base, or the assignment of an arbitrary ratio of beds to deaths. Furthermore, the results of this technic are related to bed requirements according to precise distribution of population; therefore it is effective in estimating bed requirements for a geographic section of the total area studied whereas the Hill-Burton formula and bed-death formula are best applied in determining bed needs for a large area.

Also, calculations based on the age composition formula may be adjusted according to known and measurable factors which affect the use of hospital facilities of a given community. For example, adjustments in the obstetrical service can be computed on the basis of the actual birth statistics for the service area.

Following are the factors used in this method:

STANDARD FOR AGE COMPOSITION FORMULA

Average Annual Number of Bed Days

Age Group	Male		Female		
	Medicine	*Surgery*	*Medicine*	*Surgery*	*Obstetrics*
13-15	.18	.49	.14	.56	—
16-17	.18	.39	.19	.35	.28
18-30	.16	.32	.13	.19	1.03
31-40	.32	.50	.32	.46	.98
41-50	.69	.76	.55	.95	.36
51-60	1.12	.68	.89	.91	—
61-70	1.27	.71	1.17	.81	—
Over 70	1.39	.73	1.39	.73	—

The following is abstracted from a speech given at the recent Association of Western Hospitals' meeting.

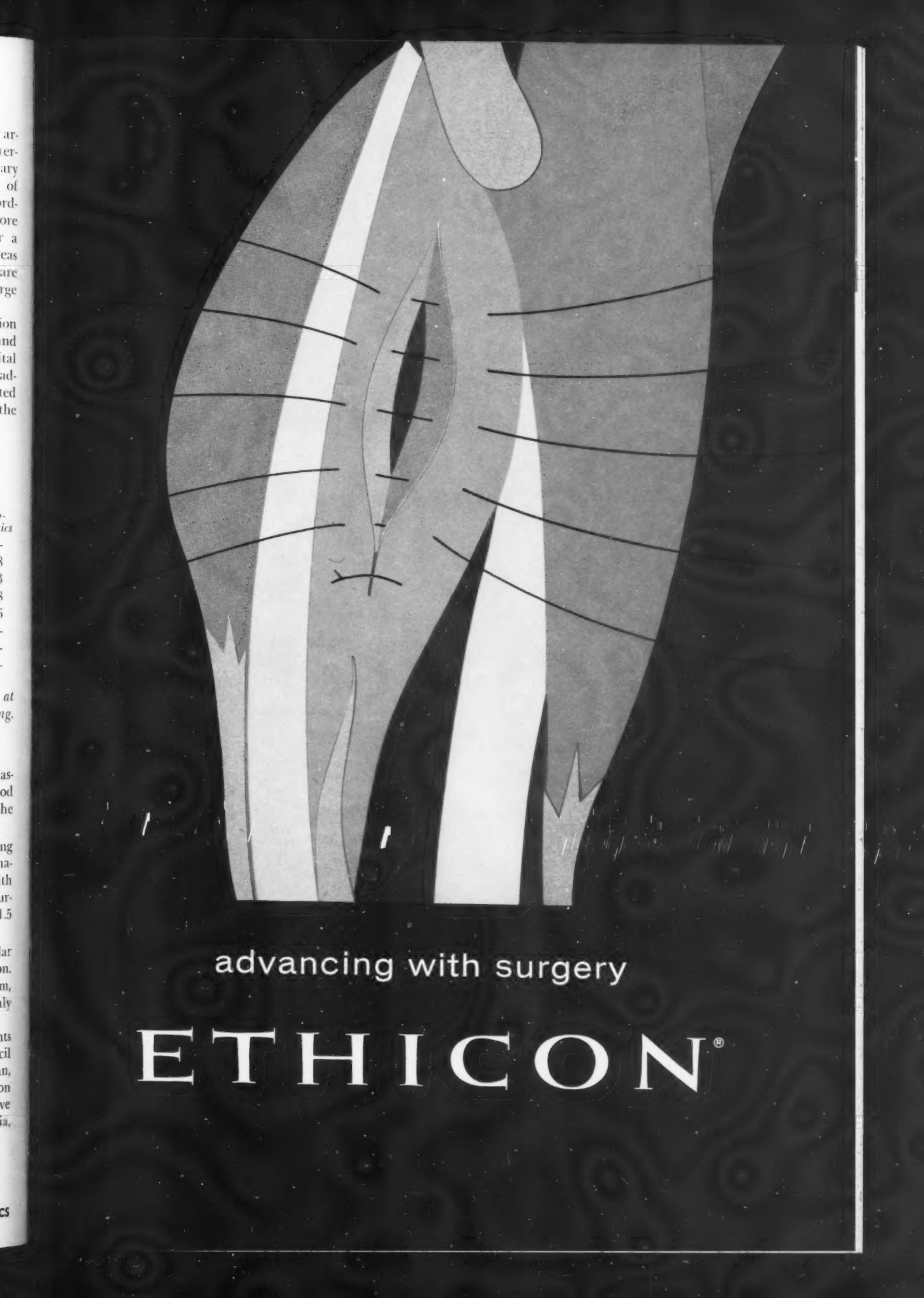
Large, Small Hospitals Benefit From Group-Purchasing Programs

There is no place left to turn but to group purchasing to improve our purchases. Though this method may offer more savings to the small hospital, the large institution will benefit too.

In Philadelphia, large hospitals have been making most use of group purchasing, according to information on the first five or six years' experience with the method. In Boston, the value of supplies purchased in this way has gone from nothing to $1.5 million per year in less than six years.

Fuel oil accounted for the largest annual dollar volume in the group purchasing program in Boston. A large amount of the total went for x-ray film, linen, and paper, and a fair amount for monthly supplies, housekeeping supplies, and food.

Group purchasing can make purchasing agents more important than ever. If the Hospital Council of Southern California goes ahead with the plan, we're counting on the council's purchasing section to supervise the effort. — *W. Glenn Ebersole,* executive director, Hospital Council of Southern California, Los Angeles.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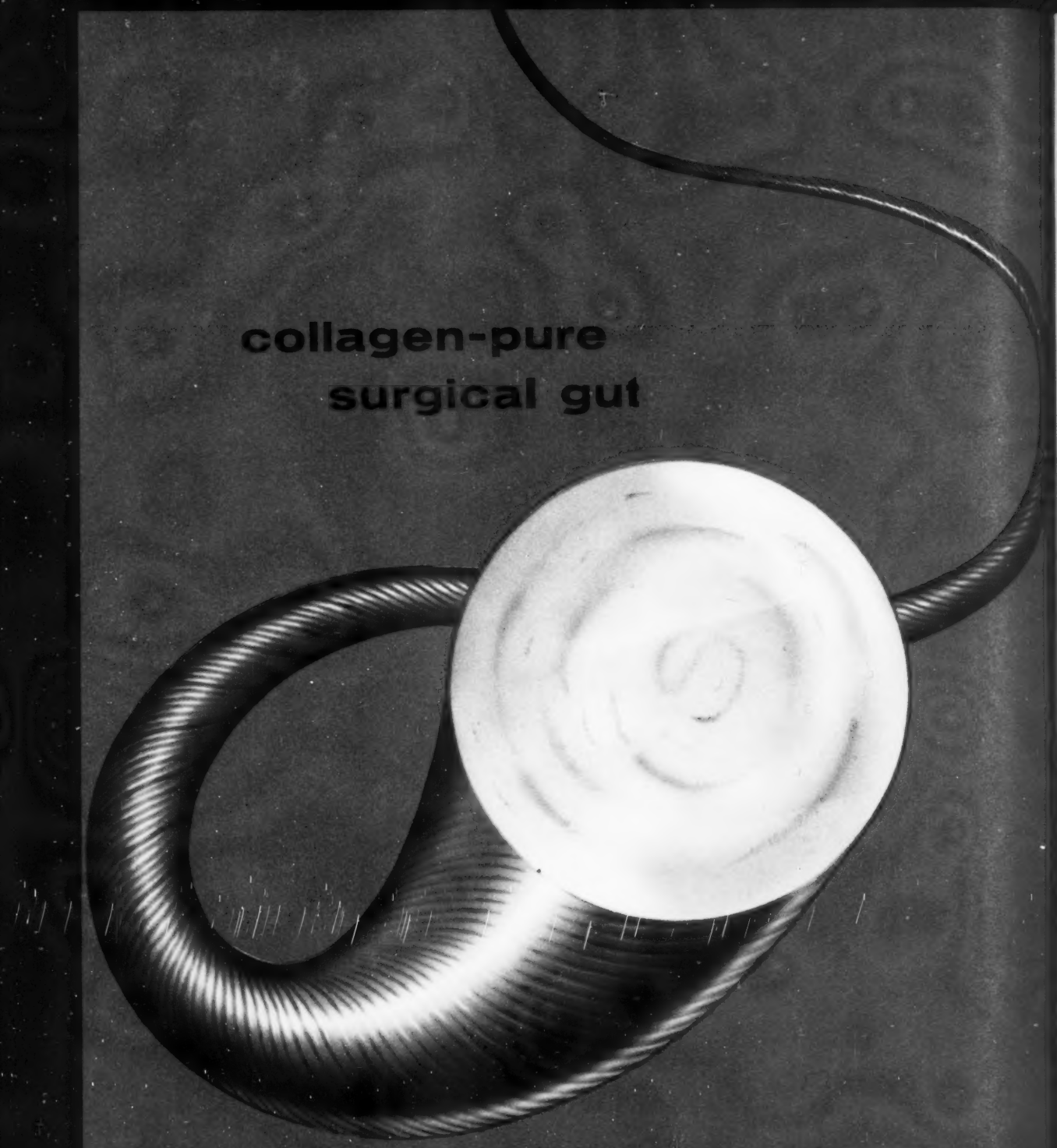

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Heart Surgery Technics, Cardiac Arrest Prevention Discussed in ACS Courses

The postgraduate courses in surgery are popular features of the annual clinical congress of the American College of Surgeons. In the following report, TOPICS' *nurse consultant, Dorothy W. Errera, R. N., presents abstracts of selected lectures from the postgraduate courses at the 1960 congress, held in San Francisco October 10-14. A report on the general sessions will appear in the December issue.*

Describes Technic for Long-term Use of Artificial Pacemaker

A technic of heart pacing employing an electrode in a conventional intracardiac catheter has been used in 23 patients, ranging in age from 48 to 81 years. Twenty-one of the patients had atrioventricular dissociation with Stokes-Adams seizures. One patient, paced in May, 1959, still wears the apparatus. The first case, treated in August, 1958, was a 76-year-old patient who is alive today and no longer needs the indwelling apparatus.

The fact that no anesthesia is needed with this technic is a distinct advantage. The catheter with the electrode in place is passed through the jugular and down into the lower right chamber of the heart. The procedure is done under fluoroscopic control so that placement is accurate. A second indifferent electrode is implanted in the skin of the chest.

Initially, electrodes were monofilament wire, which often broke inside the insulation. Braided wire has eliminated this nuisance. The tip of the electrode still does not rest as securely as desired, and breaks in insulation are always possible.

It is important that no apparatus connected to wall current ever contact these wires. Three deaths have occurred in patients who developed ventricular fibrillation from leakage of current from wall outlets.

To date there have been no hearts that did not respond to the technic. One disadvantage, however, is the risk of infection accompanying the break in the integument. Six patients did develop bacteremia, which was controlled with antibiotics and replacement of the catheter in use with a clean one. The problem of clotting around the individual electrode is obviated with long-term administration of anticoagulants.

Another method of pacing, utilizing the external pacemaker, may be useful temporarily, but shocks the internal chest wall, and the ulcers and burns that develop under the electrodes are painful for the patient. In patients with heart block produced in surgery, a direct wire has been planted in the myocardium. After two weeks, however, the heart becomes more refractory.

A battery impulse generator implanted on the skin with a radio frequency transmitter shows great promise, but clinical experience is limited

(Continued on next page)

to date. When the ultimate instrument is developed, it is important that it be equipped with a moderator, so that when the heart takes over on its own, it will not have to compete with the artifical pacemaker.—*Elliott S. Hurwitt, M.D.*, chief, surgical division, Montefiore Hospital, New York City.

Performing Cardiac Surgery with Use Of Hypothermia and Pump-Oxygenator

In cardiac surgery utilizing profound hypothermia with the pump-oxygenator, it is not necessary to wait for a low level of hypothermia before starting the operation. The incision can be made while the patient is still cooling. Once the cooling is finished, the perfusion is continued.

Cooling is always started on a partial bypass. Temperatures in the mid-esophagus, the rectum, and the water in the heat-exchanger are monitored. Moderate flow rates are used: 25-30 cc./minute/kg. for adults; 24-60 cc./minute/kg. for infants and children. The inflowing arterial blood temperature is kept one degree above the esophageal plateau, because the central nervous system is the greatest concern, and at this temperature the blood will continue to warm the brain and spinal cord.

Brain temperature will depend on how rapidly the esophagus is cooled and the length of time of perfusion. The brain temperature follows that of the esophagus closely in the upper ranges but cannot be assumed to be the same in deep hypothermia.

Rewarming is accomplished as carefully as cooling, to avoid brain damage. It is started gently. The inflowing arterial blood is raised to 32° C. This temperature is maintained until the heart has a regular beat. Then the patient returns to a partial bypass. Warming is discontinued when the rectal temperature is above 30° and the esophagus temperature above 30-34° C.

Using a minimum of equipment and blood increases the patient's chances of survival. Efficient heat-exchangers make it possible to apply principles of safe cooling.—*Ivan W. Brown, Jr., M. D.*, associate professor of surgery, Duke University School of Medicine, Durham, N. C.

Problems of Heart Transplantation: Impossible to Transplant Both Lungs

The technic of heart transplantation is purely experimental. The problem is to maintain the heart while it is out of the body and to have it maintained in the recipient animal. If one can prevent the development of small clots in the capillary system, one can maintain the heart at room temperature for at least 90 minutes.

If the heart is refrigerated at 4° in nutrient solution, it can be maintained up to six or eight hours with excellent function and tone; up to 24 hours with some function, and up to 36 hours with minimal function. This means there are about eight hours available in which the procedure can be done.

Including both lungs in the transplant with the heart facilitates the technic. It is done in such a way that at no time is the heart's function totally interrupted. This should work well, but unfortunately it doesn't. All the animals eventually die of respiratory causes. It is apparently physiologically impossible to transplant both lungs.

Transplanting with one lung involves many more anastomoses, but the animal is able to breathe and survives longer periods of time. Stainless steel couplers are used to hasten anastomoses of veins. The right lung is the easier of the two to transplant because of its connections. The heart, once removed, is infused through the atrium with lactated Ringer's solution at room temperature to remove all blood from the capillary circulation.

To date, transplants have been to the dog's neck, with anastomosis to the proximal carotid artery. The pericardium is maintained over the heart at all times during the procedure. Tiny amounts of calcium chloride and adrenalin may be used to restore the heart beat.

The not-too-distant future may see great developments in the technic and survival times.—*Watts R. Webb, M.D.*, assistant professor of surgery, University of Mississippi School of Medicine, Jackson.

Better Training Raises Resuscitation Rate in Cardiac Arrest Cases

The current rate of cardiac arrest, countrywide, is about one in every one or two thousand cases. A resuscitation rate of 20 to 30 percent is usual. The incidence of cardiac arrest has not decreased at the Los Angeles County Hospital, but 70 percent of patients in arrest have been resuscitated in the last six years.

Our increased effectiveness in treatment is believed to be the direct result of a training course which is available to all physicians in the area.* Any physician can resuscitate a patient in arrest, but he needs some confidence to manage the problem. He need not be a thoracic surgeon, but he does need some practical experience in dealing with the situation.

In making a diagnosis, one should suspect arrest if there is a sudden disappearance of pulse and blood pressure, and continue to suspect it until some other diagnosis can be proved. Palpation of a major artery—such as the femoral, which is always available—can be relied upon to confirm the diagnosis. If there is no pulsation, treatment for arrest is begun.

It should not be thought that there is a grace period of three minutes, because some time may have elapsed before failure was noted. There is

*This course is described by Dr. Mikkelsen in the article, "Cardiac Arrest and Resuscitation," which appeared in the June, 1957, issue of HOSPITAL TOPICS, pp. 96-99.

a distinct relationship between the time wasted and the salvage rate. Ninety to 95 percent of patients will be lost if three minutes are wasted.

Three or four firm blows on the precordium will occasionally start the heart beating. If this maneuver is to be effective at all, it will be immediately so. If it is unsuccessful, the closed-chest method of resuscitation should be tried for 15 seconds.

The closed method, which has been successful in the hands of some investigators, is obviously preferable to the open method. The sternum is depressed with both hands. The patient must be on a firm surface. As one presses down, the sternum compresses the heart against the backbone, and circulation should be inspired.

If pulse rate and color improve during the 15-second trial of this method, all is well. Otherwise, thoracotomy is indicated.

Because there will be no bleeding in a patient in arrest, and cosmetic result is unimportant, a bold incision is made in the left chest beneath the area from the border of the sternum to the mid-axillary line. The interspace used is unimportant, but the technic of massage is very important, because a systolic blood pressure of 100, once attained and maintained, will keep a patient alive for a long time.

Most patients in cardiac arrest are in ventricular standstill and can be resuscitated in 20 to 30 seconds of massage. Good function should be obvious in less than one minute of massage. If after this time there is no response, use of epinephrine and calcium chloride may be indicated. They should be injected directly into the heart, so that they will be distributed to the coronary circulation as the heart is massaged. Epinephrine is more potent but is quite likely to convert the heart to standstill.

An electric defibrillator using the shortest time interval available, 1/10 to 1/20 of a second, with the maximum output, 160-280 volts, is helpful. If defibrillation is still difficult, one percent procaine may be tried.

Once the heart is started, cerebral resuscitation may be a problem. If additional anesthesia is not necessary as the chest is closed, it can be suspected that the patient will remain in coma, and hypothermia, down to 28-30° C., must be started immediately. Cooling must be achieved in seven hours to be successful. Thorazine in large doses is necessary to control the patient's shivering, or else he maintains his body temperature.

The patient is kept at 28-30° C. for 12 to 24 hours. In this time, it is impossible to evaluate his mental status. He is then allowed to drift up to 34° for evaluation. If he shows signs of awakening, he is allowed to drift to 36°, and then, if he is still awake, allowed to come up to normal temperature. If he is still comatose at 34°, he is taken back down to 28-30° for another 24 hours.—*William P. Mikkelsen, M.D.*, Los Angeles.

Lists Causes of Cardiac Arrest, Recommended Steps in Prevention

Cardiac arrest occurs characteristically in healthy patients scheduled for surgery unrelated to the heart. There are several possible causes: a disturbance of the vaso-vagal reflex, as during intubation and extubation; a change in blood pH, or anoxia, which is sometimes due to such a simple cause as forgetting to change the carbon dioxide absorber on the anesthesia machine. Cardiac arrest may also follow massive blood loss.

Preoperative administration of atropine and an operating team alert to the patient's condition during intubation and extubation are essential for the prevention of cardiac arrest. A clear airway and good oxygenation are obvious necessities. A dose of calcium gluconate after every two transfusions of ACD blood when multiple transfusions are in order will minimize the risk of arrest from this source. Repeated infusions of cold blood may make the heart hyperirritable and induce arrest.

An esophageal stethoscope, fitted with ear plugs, is incased in a condom attached to a catheter. This is passed in all patients having general anesthesia, and the anesthetist listens continuously to the heart beat.

The professional staff of any hospital should be prepared (by animal demonstration and practice) to treat cardiac arrest. In addition, fully equipped emergency carts should be ubiquitous throughout a hospital.—*Ben Eiseman, M.D.*, associate professor of surgery, University of Colorado School of Medicine, Denver.

Preventing Thrombophlebitis In the Postoperative Patient

Ambulation to nurses often means getting a patient out of bed to sit in a chair and then lifting him back to bed. The patient must get up and walk if ambulation is to have any significance in preventing thrombophlebitis. He should either be up walking or flat in bed with his legs elevated. Conservative measures of heat and elevation are important in the treatment of thrombophlebitis.

Ace bandages are not used unless applied by the physician. Too often, when applied by an unskilled person, the Ace bandage acts as a tourniquet.

Anticoagulants are important and are started four hours postoperatively. Fibrinolytic agents are ideal, but proper dosage is essential. A priming dose may be about 100,000 to 200,000 units. This is repeated every two or three hours for at least 36 hours. The expense of therapy is impressive; 50,000 units cost about $50.

When the prothrombin is down 40 percent, dosage is eased off. Because the original factors producing the clot may still be present, the patient is continued on anticoagulants when the fibrinolytic agent is stopped.—*Frank H. Leeds, M.D.*, assistant clinical professor of surgery, University of California School of Medicine, San Francisco.

Westerners Turn Out for Walter's Institute

Sister M. Canice (l.), central supply supervisor, St. Agnes Hospital, Fresno, Calif.; Sister Mary Loyola, O.R.S., St. Alphonsus Hospital, Boise, Ida.; and Beth Dunn, Santa Ana (Calif.) Doctors Hospital.

One hundred six persons – from eight states and Sweden – registered at the institute for operating-room nurses presented by Carl W. Walter, M.D., in Arcadia, Calif., in September. The lone Swedish registrant was Olof Olsson, M.D., Sahlgren Hospital, Gothenburg, Sweden.

Though most of the nurses who attended were from California, there were also registrants from Arizona, Idaho, North Carolina, Tennessee, Texas, Utah, and Washington.

Sessions in the week-long course were held at the Methodist Hospital of Southern California.

◀ Mrs. Evelyn Coon, R.N. (third from left), director of nursing, Methodist Hospital of Southern California, with group of students from Pasadena College School of Nursing.

Reaching for a cup of coffee (above) is Agnes Farr, O.R.S., Auburn (Wash.) General Hospital, who is talking to Bethene Zahm, assistant O.R.S., Methodist Hospital of Southern California. In photo at right, Gladys House (l.), O.R. clinical instructor, White Memorial Hospital, Los Angeles, exchanges greetings with Sister M. Jerome Emilian, O.R.S., St. Mary Desert Valley Hospital, Apple Valley, Calif. In background is Elaine H. Piazza, O.R.S., Community Hospital, San Gabriel, Calif.

The subject matter is serious, but not without its light touches. Here the audience responds to some humorous comments by the professor. Seated at right in front row are Shirley Howe, O.R.S., and Sister Joseph, central supply supervisor, both of Mercy Hospital, Merced, Calif. Behind them is Florence Friedman, O.R.S., City of Hope Medical Center, Duarte, Calif.

The professor also took time out for coffee and rolls. Dr. Walter is shown here with one of his students, Anne Merkir, O.R. staff, Tahoe Forest Hospital, Truckee, Calif.

Sister Patrick Bernard, O.R. staff, Daniel Freeman Hospital, Inglewood, Calif., took advantage of a few free moments to make a phone call.

During a coffee break, Olof Oisson, M.D., assistant professor of surgery, Sahlgren Hospital, Gothenburg, chats with Bethene Zahm, assistant O.R.S., Methodist Hospital of Southern California, and Sister Ann Thomas, operating-room staff, Daniel Freeman Hospital, Inglewood, Calif.

Drape for Transurethral Prostatectomy

By Jack Lapides, M.D., Nancy J. Conway, R.N. and
Theresa A. Zapp, R.N.**

Several years ago it occurred to us that our set-up for transurethral prostatectomy needed modernization. Our drapes at that time included the usual lithotomy sheet and two leg covers. Defects observed with these materials included (1) necessity of having another person in the operating room to tie the lithotomy sheet in place, (2) intermittent poor drainage of irrigating fluid from the drain pan because the drain opening in the lithotomy sheet had slipped upward, and (3) multiple collections from the drain pan and bucket to obtain all of the resected prostatic tissue.

In order to obviate these difficulties, a one-piece drape was devised. The drape can be applied to the patient by the surgeon without aid from other personnel. Drainage of irrigating fluid from the pan is improved because the drainage opening in the drape has been enlarged to the size of the drainage pan. The collection of prostatic tissue following operation has been simplified by incorporating a cloth mesh into the drainage opening of the drape; thus all of the resected tissue will be found on top of the mesh instead of in the drainage pan and pail.

The materials used in making the drape include pre-shunk unbleached muslin, and mesh obtained from the net laundry bag† commonly used by hospitals. The drape can be made readily in any hospital linen room.

Figure 1 depicts the dimensions of the drape in inches. Note that the opening for the genitals measures 5 by 7 inches and the size of the mesh for drainage is 9 by 12 inches; a double thickness of mesh is employed. The portion of the drape used to cover the lower extremity measures 47 by 56 inches.

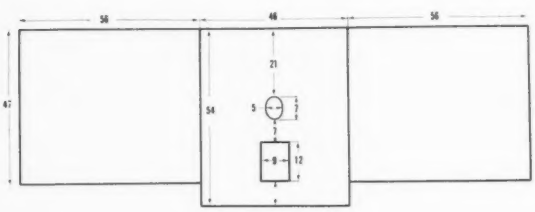


Figure 1

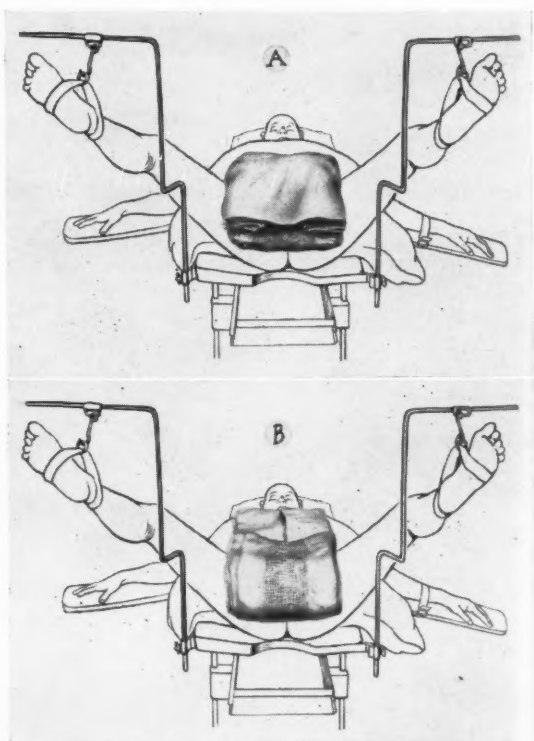


Figure 2

*Reprinted with permission from the January, 1960, issue of the *Journal of Urology*, published by the Williams & Wilkins Co.

**From the section of urology, University of Michigan Medical Center and VA Hospital, Ann Arbor, Mich.

†Leno weave laundry net obtained from Fry Brothers Co., 3600 Cardiff Ave., Cincinnati, O.

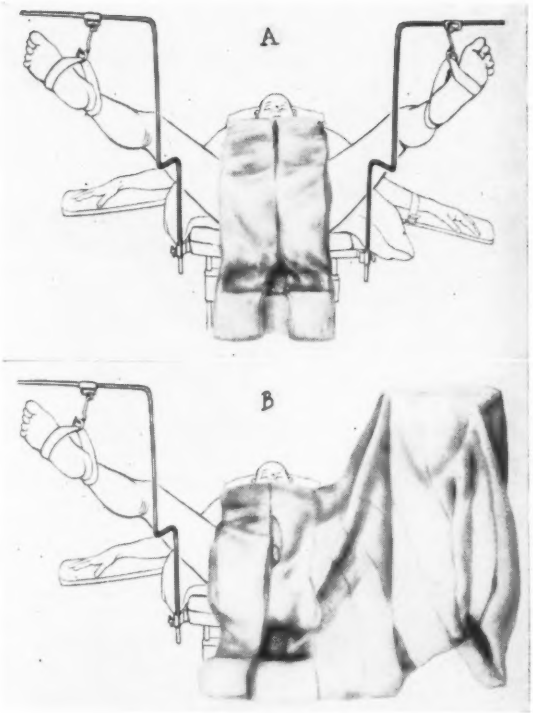


Figure 3

The sheet must be folded in a particular manner in order to simplify draping the patient. Essentially each leg piece is accordian-pleated toward the center. This results in a rectangle with a length of 54 inches and a width equal to the two

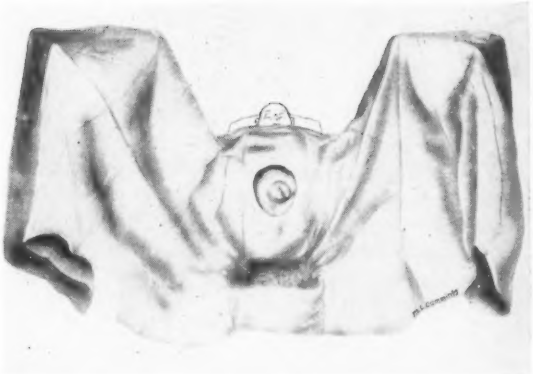


Figure 4

leg folds. The rectangle is made into a square by folding the lower portion of the drape upward and the upper part of the drape down upon the folded lower segment. The underside of the squared drape presents the opening for the external genitalia in its center.

To drape the patient one first pulls out the drain pan. The folded drape is now placed upon the patient's genitalia with the opening for the genitalia overlying the genitalia (fig. 2, A). The end of the drape presenting anteriorly is thrown cephalad (fig. 2, B) and then the lower end incorporating the mesh is unfolded upon the pan (fig. 3, A). The left leg piece is placed over the left lower extremity (fig. 3, B) and positioning of the right leg sheet completes the draping (fig. 4).

A model drape will be loaned on request.

Cystoscopic "Boom" Enables Control of Cords, Tubing

To solve the problem of entanglement of cords and water tubing during endoscopic procedures, particularly during transurethral surgery, Moreton A. Magid, M.D., a urologist in Waco, Tex., adapted a microphone boom to control these elements.

In an article for the *Journal of Urology*, Dr. Magid declares that perhaps nothing has been more exasperating to the transurethral resectionist than the constant battle to maintain the correct length of the cystoscopic light cord, the radio frequency cord, and the water source. These three elements, he points out, have constantly been either too short or too long. Excess tension developed on one or the other with inequality of weight and length causes undue tension upon the resectoscope.

In his search for a better means of controlling these elements, Dr. Magid first tried suspending the elements by grouped rubber bands above the patient's pubic area. Though this worked fairly well, the elements were never evenly balanced.

"If all elements were of equal length then, when the working element of the resectoscope was completely removed, the light cord was too short. When left long enough for the maneuver, then it dropped

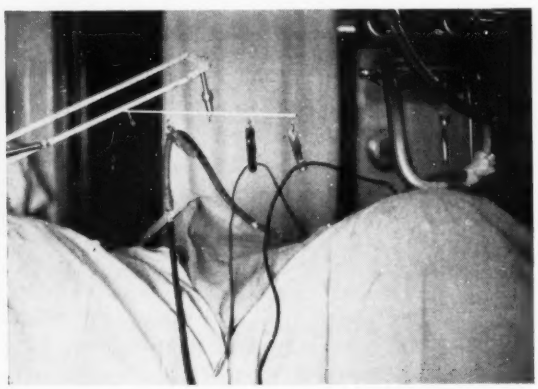
(*Continued on next page*)

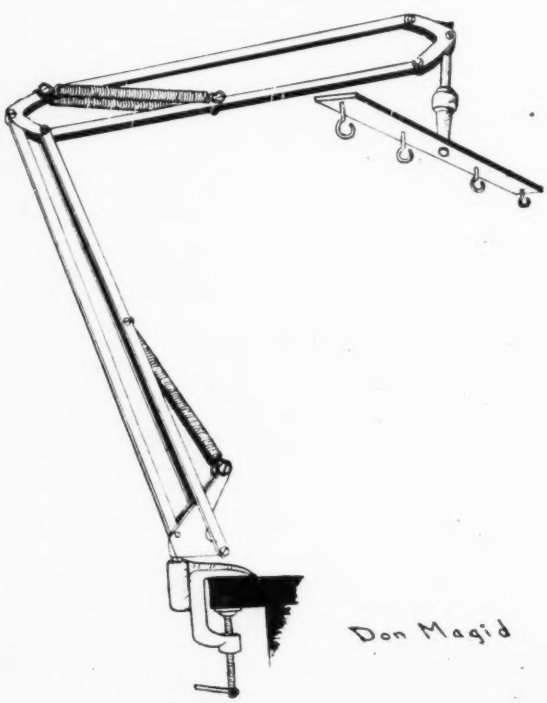
"A New Boom for Cystoscopic Procedures," by Moreton A. Magid, M.D. The *Journal of Urology* 82:1, July, 1959. The photographs which appeared with Dr. Magid's original article are reproduced here through the courtesy of the Williams & Wilkins Co., publishers of the *Journal of Urology*.

over the eye piece or was in the way of the working element," Dr. Magid comments in the *Journal's* article.

The Foley arm, which was designed to carry the water, light and radio frequency cords, was found to lack flexibility. Because the light cord can pick up radio frequency energy, it should not be in too close proximity to the radio frequency cord from the surgical unit, Dr. Magid warns. Furthermore, the light cord should not run in metal tubing, because the cystoscope bulb will brighten when the radio frequency unit is energized and burn out if the absorption is too great.

In addition, Dr. Magid points out, the cord from the electrosurgical unit should not be encased in the metal tubing because the capacity effect would be great enough, at the high frequency generated, to cause the current to be by-passed to the ground, and, in turn, there would be lack of cutting or coagulation.





Dr. Magid decided to try some sort of boom to control these extra cystoscopic elements. He investigated several different types which he found unsatisfactory. Though all were adjustable, after being adjusted they were fixed in position and did not have the necessary mobility.

Finally, a microphone boom which is manufactured commercially gave him the results he wanted. The "cystoscopic boom" which he devised is mounted on a C clamp and swivels freely on a central axis. The boom's double frame is spring-loaded so that it maintains its position and may be changed to any new position with the slightest pressure.

The tubing and cord-holding mechanism was made from a one-foot piece of aluminum with eyes to hold plastic clothespins. The elements are well controlled, as the accompanying illustrations show.

In usage, the boom is clamped to the film tray of the cystoscopic table. The cassette carriers are withdrawn approximately two inches. After the patient is prepared, the sterile clothespins are engaged on their individual hook-eyes and the cords are clamped one foot from their ends. The cords are attached to the resectoscope; the boom is raised to extend the cords, and then is set to have the slightest positive loading.

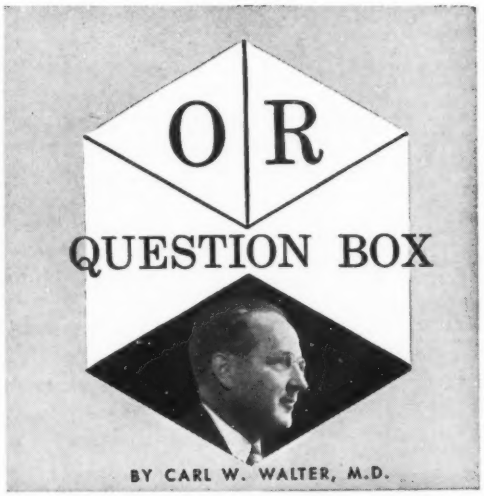
The boom follows the operator through the resection, swinging outwardly when the resectoscope is removed and toward the patient's head when it is replaced. The boom raises and lowers with the slightest pull on the cords. The cords and tubing are always out of the way.

The advantage of this equipment, says Dr. Magid, is that the boom holds the cords at the proper levels and seems to swing with the resectoscope. The cords are set at the proper lengths, and the boom, at the completion or during the procedure, may be elevated in order to hold the resectoscope without additional support. With slight relaxation of the boom, the cords are very flexible and follow the instrument.

The equipment has been in constant use for four years at two Waco hospitals, and has given "the ultimate in satisfaction," according to Dr. Magid. There has been no maintenance problem with it, other than the occasional replacement of a plastic clothespin. Several booms have been made for urologists in nearby cities, and they too have been most pleased with the equipment.

AORN Highlights in December

Program highlights for the eighth annual congress of the Association of Operating Room Nurses, to be held in San Francisco February 13-17, will be published in the December issue of HOSPITAL TOPICS. The preliminary program and detailed information on congress plans will appear in the November-December issue of OR NURSING.



Assisted by Dorothy W. Errera, R.N.

Q. Can sterile supplies be stored safely on open shelves in the operating room?

A. Air-borne bacteria are not the chief cause for concern in this instance. In a clean operating room, there is little dust to settle on exposed kits and packages. In an efficiently-run operating room, shelf stock is inventoried so that supplies are current. The sterile kit or package kept for occasional emergency use is protected with an outer wrapper of plastic or paper.

Sterile supplies on open shelves in an operating room where a septic case has been treated are in jeopardy only if they are within range of splashing from the field. Storage shelves at the periphery of the operating room are far enough removed from the focus of sepsis to be considered safe, provided that dust, lint and dirt are controlled with sanitizing housekeeping practices.

Insects and moisture constitute the major threat to sterile supplies. Wrappers may be wet with the excreta of insects, mouse urine, or condensate from air-conditioning ducts or cold water pipes. Sterile supplies on tables in sterilizing rooms are in particular peril because steam will condense on a cold ceiling, and the condensate will drip onto exposed sterile instruments or packages. The enthusiastic aide dusting shelves with a sopping wet sponge or rag is also a threat.

Insects, of course, are ubiquitous, and a continuing program of extermination is a must in almost any locale. Discipline and planning are needed to protect packages from the exterminator's spray or from seepage from a shelf imperceptibly moist with insecticide.

Q. If rubber bands are contraindicated on glass ampoules being steam-sterilized, why do so many people use them to hold sponges together during sterilization?

A. A rubber band around a glass ampoule fits snugly – so snugly that steam is unable to sneak under the band, and, of course, it cannot penetrate the band. Steam sterilization depends on steam having easy access to all surfaces to wet, heat and sterilize.

Eventually, the glass does conduct heat to the surface protected by the rubber band, but it is dry heat; there is no moisture present. The thermal death time for destruction of pathogenic organisms in dry heat is much longer than the usual 30-minute cycle of a steam sterilizer. Hence, the surface beneath the rubber band is not sterilized by moist heat because the steam can neither penetrate the band nor seep in around it; neither is it sterilized by the dry heat conducted by the glass surface, because the exposure is too short.

Gauze sponges, on the other hand, are adsorptive and absorptive. They will take in steam throughout their fibers and become saturated, and moist heat will pass through to contiguous surfaces. Hence, the area protected by the rubber band is attacked from below, so to speak, by steam which fills the sponge's meshes. Thus, both the under side and upper surface of the rubber band are contacted by moist heat and sterilized, and the area under the band is in contact with a wet, heated sponge.

But there is an important reason for avoiding the use of rubber bands on sponges. The bands are often old, weak, and ruined by heating. They decompose, and tiny fragments adhere to the sponge. These bits are not immediately visible. If implanted in the wound, they constitute a potential foreign-body reaction – a needless insult for the surgical patient who may already be overwhelmed with debility, disease or infection.

Q. How can an abscess be sterile?

A. A sterile metal implant in the body may be attacked by body fluids. Electrolysis occurs and an abscess results. There are no bacteria present—only chemical irritation around a foreign body which will eventually be extruded.

Q. How long should Tygon tubing be allowed to rest after sterilization in ethylene oxide?

A. Tygon tubing can be used once it is clear. This usually means about two days after exposure to ethylene oxide.

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SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Cheek, David B.: "What Does the Surgically Anesthetized Patient Hear?" *Rocky Mt. Med. J.* 57:59, January, 1960.

Maybe too much, the author answers.

The sense of hearing is apparently maintained at the great depths of chemical intoxication that accompany anesthesia, even when all other perceptions and common reflexes are suppressed. Every anesthetized patient should be treated as though he were capable of hearing.

Using hypnosis for recall, the author studied the operative experiences of 212 subjects. One woman became very angry when she recalled that her surgeon had invited an assistant to remove her ovarian cyst.

Another patient who postoperatively had an intense dislike of her surgeon which had not been characteristic of their relationship before surgery recalled that two visiting surgeons had been invited to witness her surgery. She considered this an invasion of her privacy.

Another patient after surgery abused the entire hospital staff, whereas before her operation she had been pleasant and amenable. She recalled that during the operation the surgeon had discussed the severity of her cancer with members of the team, but when he visited her postoperatively, he had denied the existence of any malignancy.

The subconscious mind of the anesthetized patient may also be keenly aware of reassuring suggestions that can be used to favorably influence the course of the postoperative period.

The author has also found patients who, even when unconscious with diabetic coma, concussion, and turpentine intoxication, were able to hear meaningful sounds which they recalled during hypnosis.

The assumption is that the hearing sense is maintained as the last communication with the environment in times of danger.

Gimbel, Nicholas S.: "Preoperative and Postoperative Considerations in Extensively Burned Patients." *Surg. Clin. of North America* 39:1583, December, 1959.

Included in an outline of treatment of severely burned patients is a word of caution for operating-room personnel. They are urged to move quietly and without loud conversation so that preoperative medications will not be frustrated.

The anesthetist is urged to delay the beginning of anesthesia until the entire team and supplies are assembled and ready to work. A large team is useful, the author believes, because the time of surgery can be shortened. The size of the team must of course be compatible with the work space available.

In the author's opinion, it is virtually impossible to perform a sterile phlebotomy away from the operating room. He suggests that if a cut-down is indicated, it be accomplished in the operating room, where lighting, positioning, and asepsis assure preservation of the precious veins instead of the mutilation and subsequent septic phlebitis that accompany the cut-down done in the patient's room.

(*Continued from page 57*)

greatest number of thromboembolic complications.

Results of the study demonstrated that all of the patients manifested to some degree, thrombocythemia and blood hypercoagulability, especially during the operative period. Three patients, demonstrating the most prominent alterations in the blood, died of thromboembolic complications. —*J. George Sharnoff, M.D.*, pathologist, Mount Vernon (N.Y.) Hospital.

RPCF Syphilis Test Comparable to TPI

The most easily and economically performed serologic test based on use of the *Treponema pallidum* for the detection of syphilis is the Reiters protein complement-fixation (RPCF) test. It has been demonstrated to compare favorably with the *Treponema pallidum* immobilation (TPI) test, and can be used to detect biologic false reactors.

Patients from those admitted to a general hospital and a university outpatient clinic for a period of one year were screened with Wassermann, Kahn, and VDRL cardiolipin tests. All of the positive tests were checked by means of RPCF.

The series consisted of 15,378 patients, of which 218 were positive with a cardiolipin test. Fifty-five percent of these patients were negative reactors with the RPCF test, resulting in a total incidence of 0.8 percent that were biologic false reactors to cardiolipin tests.

At the present time, patients from the same sources are being screened with RPCF and Kahn tests. All of the positive results are checked with the Wassermann and VDRL tests.

The present group is small, numbering only 2,009 patients, but of 43 patients who are positive with the RPCF test, five would have escaped detection with a cardiolipin test. The total incidence of failure of a cardiolipin test to detect positive reactors is 0.4 percent.

We have noticed a sudden increase, almost two times, in the incidence of positive reactors with the RPCF test. This observation may have epidemiologic significance.—*Opal E. Hepler, M.D., and Thorne J. Butler, M.D.*, Chicago.

Pediatrics Fellowships Again Offered by Wyeth

Wyeth Laboratories has announced that applications are now being accepted for its 1961 pediatric residency fellowships.

The Philadelphia firm, for the fourth consecutive year, is offering 20 two-year grants to encourage qualified doctors to pursue postgraduate resident training in pediatrics.

Each grant carries an annual stipend of $2,400, and will be awarded on the basis of the applicant's interest in pediatrics, his character, conscientious and able performance of duties, and academic competence.

Those eligible for the fellowships are interns, research fellows, and physicians who have recently completed their internships, military service, or U. S. Public Health service tours. Recipients must be citizens of the U. S. or Canada and have a doctor's degree in medicine.

Applications should be submitted to Dr. Philip S. Barba, School of Medicine, University of Pennsylvania, Philadelphia 4.

AAMRL Schedules Basic Institute

An educational program to assist the non-professional worker in the field is being offered by the American Association of Medical Record Librarians, according to Laura Anne Biglow, education director.

The Basic Institute, to be held in Miami Beach November 7-11, is aimed at bridging the gap between the small supply and the large demand by hospitals for registered medical record librarians. The course is open to personnel currently employed in medical record departments in hospitals throughout the U. S.

Subjects to be covered in the program include medical record personnel ethics and professional qualifications; component parts of a medical record, and medico-legal aspects.

ANA's New Compendium Of Facts About Nursing

Nurses interested in facts about themselves can turn for the answers to the 1960 edition of *Facts About Nursing*, just published by the American Nursing Association.

Some of the *Facts* material may surprise professional R.N. and general duty nurse alike: for example, the median monthly salary of $300 for the latter, which appears meager sounds good when compared with the $425 median accorded to directors of nursing service. Information on the distribution of nursing resources, salaries of nurses, facts about education and data on allied nursing personnel are included in the issue.

Findings include material from 48 state inventories including such relevant facts as—99 out of 100 nurses are female and 50 percent are married (only 3 out of 10 employed nurses are single); most practicing nurses are under 45 years of age.

Salary data based on a survey of employment conditions in nonfederal general hospitals, conducted by the ANA in February, 1959, shows that more than half of the active professional R.N.'s engage in hospital nursing and that their salary size is related to hospital size —the larger the hospital, the higher the salary. Salaries are highest in the Pacific region, higher-than-average in the Great Lakes region and for higher-level positions in the Middle Atlantic region.

CORRECTION

Due to an oversight in correcting material submitted for okay prior to publication, several errors appeared in the article on progressive patient care at Albert Einstein Medical Center in the May issue. On page 32, the Rosenwald Fund should be Rosenthal. On the same page, copy read that Dr. Marvin A. Gershenfeld came into the program following the death of Dr. Ellson Ravitz. It should read Dr. Elkan Ravitz, who resigned.

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This Central Service Operates the Milk Formula Room

The milk formula room is a part of the central service department at St. Mary's Hospital, Passaic, N. J. Though this arrangement is rather unusual, it has worked out very well, according to Sister Anita Margaret, supervisor of central service.

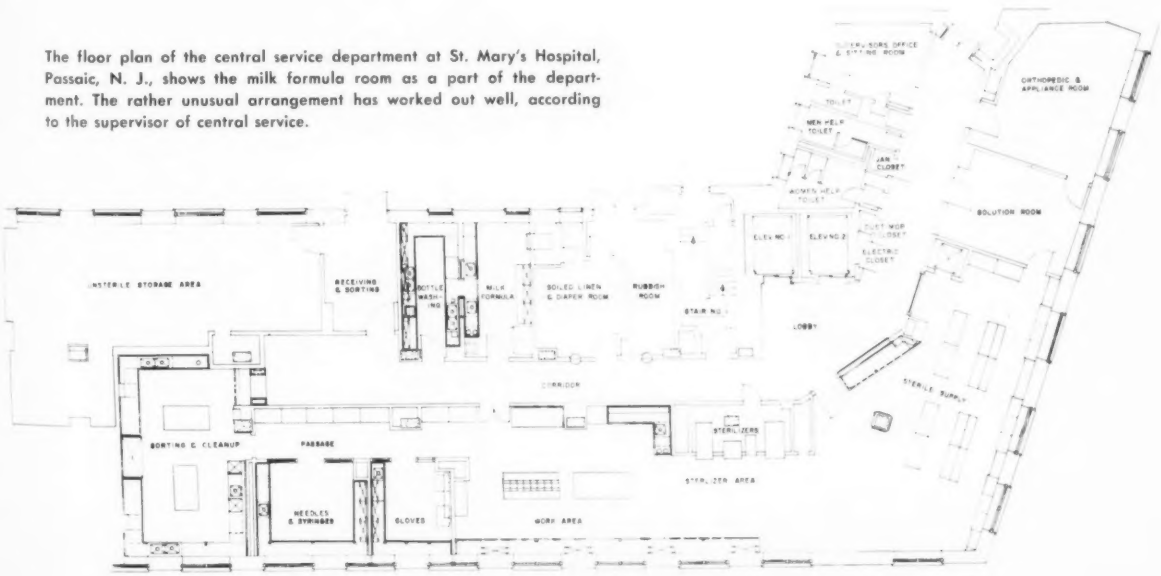
The chief pediatrician supervises the formula room, and Sister Anita is responsible to him for its operation. For the operation of the central service department as a whole, she is responsible directly to the hospital administration.

Probably the original reason for incorporating the formula room in central service, says Sister Anita, was to avoid the duplication which would have resulted if two formula rooms had been constructed — one for the delivery suite and one for pediatrics. When the new maternity suite was built, the formula room was located on its ground floor, across the corridor from the main work area of the central service department (see floor plan).

The availability of the sterilization equipment in the central service department makes it possible to use the extra precaution of double sterilization when necessary. For

(*Continued on page* 89)

The floor plan of the central service department at St. Mary's Hospital, Passaic, N. J., shows the milk formula room as a part of the department. The rather unusual arrangement has worked out well, according to the supervisor of central service.



Illustrations courtesy of S. Blackman, Inc.

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Central Service Department
Milk Formula Laboratory

DUTY No. 4—7:30 a.m. to 4 p.m.

Procedure	Related Information
I. Preparation of worker.	
1. Report to central service department.	
2. Change from street clothes into scrub dress.	Cover hair with cap, remove jewelry.
II. Presterilization of supplies and preparing of preparation area.	
1. Arrive in preparation room.	Wash hands and arms.
2. Check formula orders.	Call pediatrics and nursery.
3. Compute ingredient quantities.	Turn water indicator to red—"cold unsterile." Fill reservoir to within 3" of top of gauge.
4. Turn filtered water on in water sterilizer.	
5. Turn water off and steam supply valve on.	When temperature reaches 250° F., time for 15 minutes. When 15-minute period is up, steam-flush supply line for 15 seconds. Use pitcher from beneath work counter.
6. Turn steam supply off. Turn water cooler on until temperature of water is down to 150° F.	
7. Turn off cooling knob.	Turn indicator to green—"cold sterile."
8. While water is sterilizing, autoclave nipples, rubber bands, required number of take-home bottles.	Close by-pass valve. Set temperature at 250° F., turn pressure knob to "high," selector to "fast exhaust," timer to 15 minutes. Turn handle to "sterilize." When buzzer sounds, turn handle to "off."
9. While nipples are being autoclaved, wash all work areas and carts with detergent and water. Dry.	When sterilization cycle is completed, pull rack out on car and close autoclave door.
10. Put mask on.	
11. Obtain boat of Chix.	Moisten Chix with 70% alcohol, wipe cart top. Obtain required quantity of ingredients and wipe each container thoroughly with alcohol before placing on cart.
12. Wipe handle of water sterilizer, cooling knob, steam supply knob and tray with alcohol. Wipe refrigerator door handle also.	
13. Place formula mixing kit on far left work counter.	Unwrap so that wrapper becomes counter drape.
14. Open package of 4 x 4 gauze.	

Procedure	Related Information
15. Open gown pack. Use work area to right of hot plates.	
16. Open scrub brush on work counter to right of sink.	Scrub hands for three minutes with surgical soap and brush, dry hands (use electric dryer). Put on gown — tie at waist.
17. Arrange work counter.	Place mixing tray with utensils to far left section of work counter. Stand pitchers on base, arrange mixing spoons to right. Place nipple caps on area near splash board.
18. Transfer material from sterilization car to work area.	Nipple containers to far right. Elastic bands to the left of nipple containers. "Take home" bottles in center area, along splash board.
III. Formula preparation	
Prepare formulas in the following order:	
A) Formulas that cannot be terminally heated.	Gloves should be worn for this procedure. (Gloves should be put on after step 17 in part II is completed.) Formulas which cannot be terminally heated are placed into the refrigerator immediately.
B) Glucose water.	
C) Discharge formulas.	
D) Prescribed formulas.	
E) Supplementary feedings.	
1. Assemble formula units. Use center section of work counter. Arrange five rows of bottles, six deep in center area—leaving about 2" between and with ounce graduations turned slightly to left.	Mix formula. Pour into bottles starting with farthest bottle forward. Nipple, starting with bottle closest to you and moving to right and back, creating a new line. Cap, secure nipple guards with elastic bands in the same line without moving bottles.
2. When formula preparation is completed:	Replace bottles in carrier. Remove carriers from work counter as they are filled, to sterilizer cart. Place sterilizing rack into autoclave and begin terminal heating of formulas. Close door. Open by-pass valve. Set temperature to 212°F. Set timer for 30 minutes. Set selector at "slow exhaust." Turn handle to "sterilize." When buzzer sounds, turn handle to "off." Open door slowly; when all the steam has dissipated, pull rack onto sterilizing cart.
IV. Clean-up activities	
1. While formulas are heating, replace unused ingredient containers in storage cupboard. 2. Discard empty ingredient containers into refuse can.	Be sure to clean off any drippings on Karo or Cartose bottles.

(*Continued on next page*)

Formula room is seen through pass-through windows from the bottle-washing area. Central service aide is preparing formulas.

(*Continued from page* 87)

example, bottles from pediatrics are first sent to central service, where preliminary decontamination is performed in the main autoclaves in the work area. The bottles are then washed in the bottle-washing room and sent via a pass-through window to the milk-formula room, where they are put on racks and reautoclaved in the formula-room sterilizer.

Bottles from pediatrics and those from the newborn nursery are segregated during washing and preparation to guard against the possibility of cross-infection.

Staffing of the formula room is integrated with staffing of the rest of the central service department. Personnel in the department rotate on assignment through the various jobs (see the October issue for a discussion of the rotation system and samples of two of the detailed outlines). The formula room is considered the most advanced station in the department, and an aide usually works in the department for about a year before she is assigned to it. Her carefully kept experience record shows the supervisor what duties she has been taught and can be expected to perform competently.

Formula preparation is called "Duty 4" on the assignment sheet. The aide works from 7:30 a.m. to 4:30 p.m. Her duties are carefully spelled out in the procedure man-

(*Continued on page* 93)

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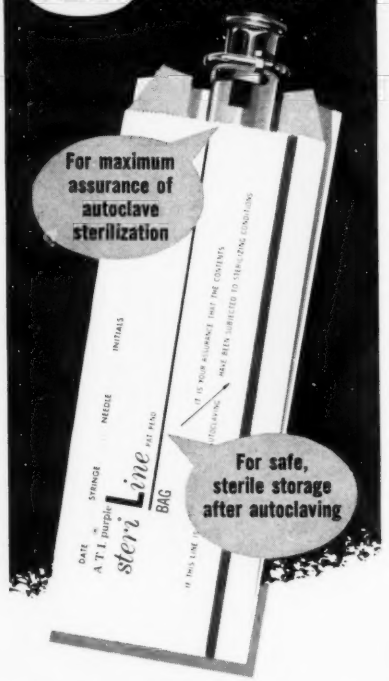

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Procedure	Related Information
3. Gather all formula-mixing utensils and place on work counter between sinks.	
4. Gather all linen and put into laundry chute.	
5. Wash inside and outside of refrigerator.	Use detergent and water solution.
6. Wash and dry utensils.	
7. Wash all work counters.	
8. Assemble mixing tray, wrap scrub brush.	Check for changes. Identify nipple caps. Wrap.
9. Remove formula from sterilizer.	
10. While formulas are cooling, package individual nipples in "nip" guards. Package 12 for pediatrics and 20 for nursery. Place in separate brown paper bags.	Close autoclave door. Close by-pass valve. Set temperature at 250°F. Set timer for 15 minutes. Fast exhaust and dry. Turn pressure regulator to "high." Turn handle to "sterilize."
11. Line stainless steel cart and place pediatrics formulas on cart.	Cover with sterile sheet. Put bag of individually-wrapped nipples on cart. Place formulas and feeding guide on cart. Place paper bag and laundry bag on bottom of cart to receive soiled bottles and nipples.
12. Sort newborn feedings according to feeding guide.	Wash hands prior to handling bottles. Identify racks according to feeding hour with tag and pin. Replace on cart.
13. Put bag of individually wrapped nipples on cart. Cover cart with sterilized drape.	Put formula and feeding guide on cart.
14. Deliver formulas to newborn nursery.	Collect old formulas and feeding guide. Collect soiled nipples and bottles.
15. Deliver formulas to pediatrics.	Collect old formulas and feeding guide. Collect soiled nipples and bottles. Place soiled bottles directly into laundry bag and nipples into paper bag.
16. Return to central service dept.	Take soiled nipples and bottles into main sterilizing cart. Autoclave for 15 minutes. Fast exhaust. Take cart into clean-up room.
17. After extra nipples have been sterilized, place scrub brush, two cover sheets and utensil kit into sterilizer.	Autoclave 250° F., 30 minutes. Fast exhaust and dry.
18. While pediatric equipment and utensils are being autoclaved, wash nursery bottles on bottle washer for next day. Wash pediatric bottles in the same manner.	Use low sudsing detergent. Rinse twice—once in rinse sink and once in automatic rinser. Examine bottles for cleanliness. Place inverted on racks. Put drained racks through pass-through window, then on sterilizing cart.

(*Continued on page* 93)

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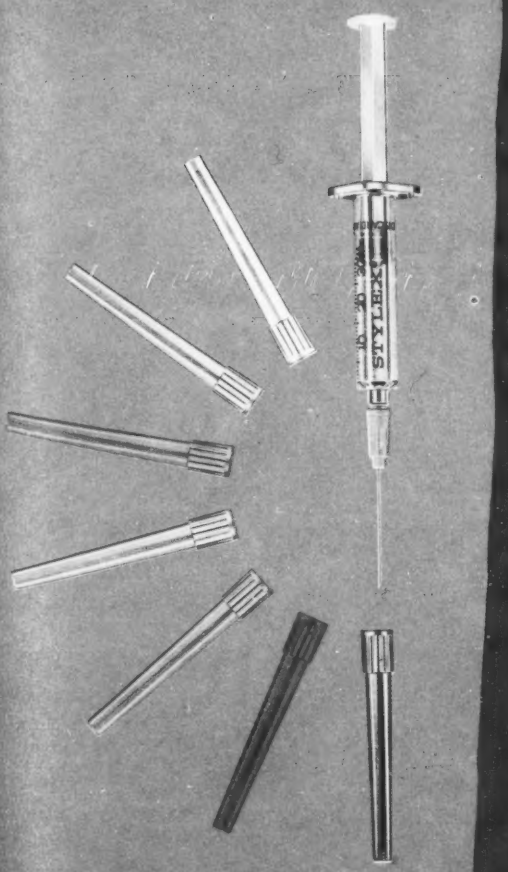

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(*Continued from page* 89)

ual for central service (see accompanying chart).

The composition of each of the 16 formulas used is listed in a Kardex file kept by Sister Anita. When a new formula is brought to her attention, she checks with the chief pediatrician to see whether it should be added.

Almost immediately after she comes on duty in the morning, the formula-room aide calls the pediatric division and the newborn nursery to check on their needs. She takes orders for new feedings or for changes in feedings at that time. She also gets information on new or revised orders when she makes her daily afternoon check of the formula record and feeding schedule. During the hours of formula preparation, orders may be given via a telephone call to the central service control desk.

Prepared formulas are sterilized by the terminal method in formula-room autoclaves. The aseptic method is used for high-protein formulas which doctors do not like to have terminally sterilized because autoclaving makes them separate and thus appear unappetizing.

The formula room contains one refrigerator, used for storing whole milk. After autoclaving, the bottles of formula are taken to one of three special refrigerators located in the workrooms between nurseries. The refrigerators provide a quick drop in formula temperature to prevent souring or spoilage.

The elimination of formula refrigeration in the formula room does away with double handling and minimizes the chances for possible spoilage.

Formulas and the feeding guide for the day are delivered to the pediatrics division and the nursery by the formula-room aide, who collects the used feeding guide and soiled nipples and bottles.

In addition to preparing and delivering formulas, the central service department takes care of all the linens for the pediatrics and maternity units. Diapers and infant shirts are supplied by an outside service.

(*Continued from page* 90)

19. Wash nipples for next day.	Wash in detergent. Compress, invert, examine carefully. Use brush as needed to remove coagulated milk. Discard worn soft nipples. Rinse twice. Store in containers on preparation side, cover with towel.
20. Wash and clean all work areas.	Wash cart in clean-up room.
21. Take cart to preparation room.	Wash hands. Store kits in designated cupboards.
22. Turn off steam supply on autoclave.	
23. Turn off lights.	
24. Close doors.	
25. Report off duty, or to supervisor for another assignment, if time permits.	
26. Periodically check:	
A) Container with Chix.	When supply is low, wash tray, fill with Chix. Place in autoclave, top off. Autoclave 250°F., 30 minutes. Turn pressure regulator to "high." Close by-pass valve. Fast exhaust and dry. Remove from autoclave. When cool, store in drawer.
B) Check alcohol container.	Obtain additional alcohol from supervisor.
C) Check linen supply	Gowns, drapes, towels, masks, scrub dresses, caps, wash cloths.
D) Check cleaning materials.	Professor Foster's cleaner, Bon-Ami.
E) Check supply of ingredients.	Order as needed from pharmacy or diet kitchen. Collect ingredients which you requisitioned from the department, dispensing them. Obtain fresh milk daily—on Saturday, enough for two days.
27. Weekly—to keep bottles in good condition and to prevent any beginning formation of milk stone, bottles should be soaked in a special cleaner prior to washing.	

"Servac"—Wyandotte Chemical Corp., Wyandotte, Mich.
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New CSR Yearbook Soon to Be Available

Volume III of the CENTRAL SUPPLY YEARBOOK FROM HOSPITAL TOPICS will be off the press by the end of December. Like the first two volumes, it will contain selected material which has been published in the central supply department of the magazine. Among the many articles to be included are:

"Nurse Plays Vital Role in Efficient CSR Function," by Carl W. Walter, M.D.; "How Our Laundry Washes, Wraps Gloves and Surgical Packs," by Charles B. Cook; "Thermo-Plastics in Patient Care Devices," by William P. Murphy, Jr., M.D.; "Sterilization of Cystoscopy Instruments and Accessories," by Leo Cravitz,, Dr. P. H., and Virginia R. Tyler, R.N.; "How to Care for Stainless Steel Equipment," by Richard E. Paret; and "CSR Planners Review Efficiency of Department," by Frederick E. Markus, Jean E. Christie, R.N., and Evelyn Trabach, R.N.

Advance orders are now being taken for the book, which will sell for $2 a copy. Orders should be sent to: HOSPITAL TOPICS, 30 W. Wasington St., Chicago 2, Illinois.

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SCANNING
(Continued from page 9)

One important discovery has already been made, according to Dr. Frances A. Hellebrandt, director of the study. An inactive arm or leg learns the same skill being developed by the opposite limb. Muscle strength is also increased on both sides.

This "cross-education" applies directly to the rehabilitation of crippled children. The performance of a disabled limb can be improved by exercising the opposite limb.

Patient Objections Promote Recovery

Patients who resign themselves to hospitalization tend to need *more* hospitalization, while those who are least amenable to hospital procedures, who show eagerness to get home or back to work, often recover more rapidly, according to Leon Lewis, M.D., director, respiratory and rehabilitation center, Fairmont Hospital, San Leandro, Calif., and Rose Laub Coser, Ph.D., associate sociologist, McLean Hospital, Belmont, Mass.

The inclination of hospital personnel, they report, is to keep the patient out of the way (that is, in bed), which takes away his self reliance and increases his dependence on the hospital. Prolonging the number of days spent in the hospital promotes the disuse and inactivity that cause deterioration of muscles and other body tissues. The seeds of deterioration are most frequently planted in the case of acute illness; restriction of mobility creates the segregation of those who are ill from those who are well and allows few things to relate to the patient's main problem—his return to health.

The researchers suggest changes in hospital structure and practice, conferences of all those involved in health "disciplines," and stress that when patients' conditions permit, they should have access to social life and activities within the hospital. Provision should also be made for day patients who may return to their homes each evening, thereby minimizing cultural and social isolation as well as hospital expense.

Brain Tissue Sends Signals From Tube

Electrical signals from pieces of brain kept alive in glass tubes for as long as two weeks have been recorded by scientists at the medical branch of the University of Texas. This is believed to be the first report of brain signals from fragments of the tissue maintained outside the body on a completely artificial medium.

The report of this achievement was made by Dr. Alastair W. B. Cunningham, Marshall Daugherty, and Billy J. Rylander. The scientists used chick embryo brain throughout their experiments.

The new research should permit scientists to find out precisely when and in what structures electrical activity first appears and how it spreads to other tissues. It may also be possible to observe the specific action of drugs and infectious organisms on brain tissues.

New CURATIVE RELIEF FOR VARICOSE AND POST PHLEBITIC ULCERS

Aero-Pulse SURGICAL LEGGING

Legging closes snugly by means of slide fastener.

Simple pump and valve provide exact pressure required.

CONTROLS, ACTIVATES DAMAGED VEINS AND TISSUES

The AERO-PULSE LEGGING has proven to be highly effective. In many cases patients previously incapacitated or seriously limited in activity are now able to return to normal living.

AERO-PULSE LEGGING is also useful as a preventive measure. By overcoming the venous stasis and driving out the excess of stagnant lymph, it reduces the potential dangers always present under these conditions.

CONSTRUCTION IS SIMPLE

AERO-PULSE LEGGING is made of canvas which closes snugly from heel to knee. This legging holds a butterfly-shaped, air-inflated rubber bladder in a pocket of the inner side. The entire lower leg is encased in a light, comfortable legging which can be worn during almost any normal activity. Its principle is such that walking is beneficial rather than harmful.

THE ACTION OF AERO-PULSE SURGICAL LEGGING

A relatively non-elastic sheath is provided for damaged veins. A pulsating pressure is produced in the legging as the calf muscles expand and contract during walking. This action literally pumps the stagnant blood and lymph in the superficial veins back to the heart. Fresh blood again reaches the affected areas; excess of extra-cellular fluid is eliminated; infection-favorable environment is no longer present, and healing occurs rapidly in most cases.

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The superior performance of DennisonWraps with regard to

Sterile Techniques in Autoclaving

***These frank questions and answers* will help you evaluate reusable double-creped paper DennisonWraps. Maybe you have asked some of these questions yourself in discussing your own autoclaving procedures.**

Q. *You say inspecting DennisonWraps is easier and safer than inspecting muslin, yet we have no trouble inspecting muslin in ordinary daylight. Why do you claim that ours is a hazardous practice?*

A. Your own tests will prove it! Take 25 muslin wrappers that have passed daylight inspection. Examine them carefully on both sides with lights above and below them. Look for breaks in fibers due to deterioration caused by repeated laundering and autoclaving. In at least one of the 25, you're sure to find broken fibers. At each break, there is only one thickness of muslin. This does not meet sterilizing requirements. With DennisonWraps, you're always safe because breaks are immediately evident.

Q. *Why do you talk of the floppiness of muslin as if it were a bad feature?*

A. Nursing arts instructors tell us that the average graduate nurse is so accustomed to handling the limp, floppy folds of muslin that she forgets her student days. She forgets the hours of classroom instruction required to teach her how to unwrap packages so that neither the muslin nor its contents are contaminated. The disadvantage of muslin's limpness is apparent when a package is unwrapped on a flat surface such as a table top. If the muslin folds flop down on the surface, two things happen. Bacteria on the surface are dislodged, and air currents are set up. The airborne bacteria can be swirled directly into the contents of the package. This is why floppiness is a bad feature.

Q. *Why are DennisonWraps safer than muslin as far as the unwrapping technique is concerned?*

A. In contrast to the limpness of muslin, double-creped DennisonWraps have a sturdier body. So, they act more predictably when unfolded. This gives the young student less of a problem in learning to control the folds. Moreover, when a package wrapped in DennisonWraps is opened, the shape-conforming paper remains cupped, providing a protective wall around the contents.

Q. *You claim rapid and effective penetration of steam through DennisonWraps. How is this tested?*

A. In two ways. First, by Densometer porosity tests which prove that DennisonWraps freely pass air under pressures encountered in autoclaving; but, not at atmospheric pressure. Secondly, by thermocouples embedded in wrapped packages in the autoclave and attached to an external potentiometer. The time required for the center of the package to reach sterilizing temperature of 121°C is the measure of effective steam penetration. Comparative tests using one layer of DennisonWraps and two layers of muslin show that steam penetration is 5 minutes faster with DennisonWraps. Laboratory reports of these tests are available on request.

Q. *What's the most practical way to introduce DennisonWraps into our hospital?*

A. Get a free hospital evaluation kit. It contains test quantities of DennisonWraps in precut sheets; glove wicks, envelopes and cases; three clinical reports which prove that DennisonWraps will increase the safety, efficiency and economy of your autoclaving operations. Ask your local hospital supply house . . . or address your request to Dennison Manufacturing Co., Dept. L-171 Framingham, Mass.

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insist on reusable

DennisonWraps

. . . identified by their exclusive hygienic imprint

The 1960-61 executive board of the American Association of Medical Record Librarians are (standing, l. to r.) Mary Rose, Cedars of Lebanon Hospital, Los Angeles, second vice-president; Alta Mitchell, Milwaukee (Wis.) County Hospital, director; Marjorie R. Quandt, Blue Cross Commission, Chicago, director; Sister M. Eugene, R.S.M., St. Catharine's Hospital, Omaha, Neb., president; Anna M. Ball, Johns Hopkins Hospital, Baltimore, Md., president-elect; Olive Johnson, University of Pittsburgh Health Center, Pittsburgh, Pa., director; M. Loyola Voelker, U. S. Public Health Service Hospital, Baltimore, director; Elizabeth Price, Presbyterian-St. Luke's Hospital, Chicago, director. Seated are Doris Gleason, Chicago, executive director and Sister M. Loretta, O.S.B., St. Mary's Hospital, Duluth, Minn., first vice-president.

Personally Speaking

The Rev. William Ray Bailey—has been appointed chaplain, Bethany Hospital, Kansas City, Kan.

Richard W. Baum — has been appointed director of personnel services, Chicago Wesley Memorial Hospital.

J. Martin Boyle—has been named an assistant director, University Hospital, University of Missouri, Columbia. He was formerly administrative assistant in charge of Hanna Pavilion, University Hospitals of Cleveland.

Richard G. Burggraf—has been appointed administrator, Palo Verde Hospital, Blythe, Calif. He was formerly an administrative hospital consultant.

James E. Brunsgaard, Jr.— has been named executive housekeeper, University Hospital and Hillman Clinics, Birmingham, Ala. He formerly held a similar position at New York University Hospital.

Jamie H. Clements—has been appointed director of development and public relations, Scott and White Memorial Hospital, Temple, Tex.

Alexander D. Cobbin — has been named assistant administrator, Northwest Hospital, Seattle. He formerly held a similar post at University Hospital, Seattle.

Cleo Coffey, Jr.— has been named administrator, Coon Memorial Hospital, Dalhart, Texas, succeeding **Melvin Weber.**

Gordon F. Craighead, Jr.—has been named director of general services, Presbyterian-St. Luke's Hospital, Chicago.

David DeBacker—associate administrator, St. Joseph's Hospital, Fort Worth, Tex., has accepted the directorship of the Gulf Coast Medical Foundation, Wharton, Tex.

J. Earl Debord — has accepted a position on the staff of the Board of Methodist Hospitals and Homes, Chicago. He previously was assistant administrator, Brackenridge Hospital, Austin, Tex., and will be succeeded in that post by **Maury Gray.**

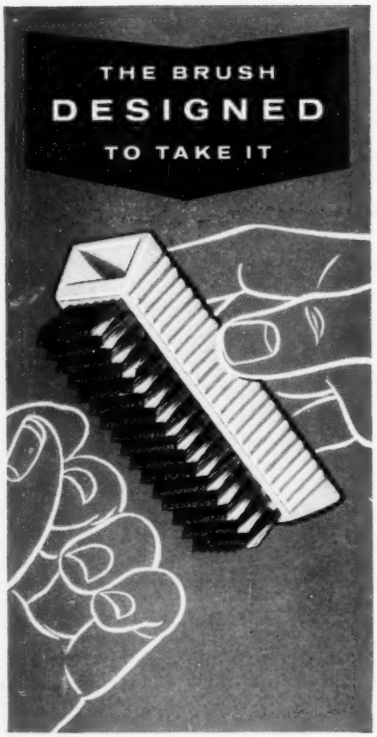
Herman Drake—has resigned as administrator, Lawrence County Hospital, Monticello, Miss.

David P. Earle, M.D. — has been appointed chairman of the department of research, Chicago Wesley Memorial Hospital. In this capacity, Dr. Earle will be responsible for the administration and coordination of all research activities at the hospital, including supervision of applications for research grants and appraisal of the work of the various investigators.

Dr. Earle has been clinical investigator and professor of medicine, Northwestern University Medical School, Evanston, Ill.

Bob Ford—has been named administrator, Brazos Valley Hospital,

(*Continued on next page*)



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Navasota, Tex. He was formerly superintendent of the Iola (Tex.) public schools.

Virginia E. Foutz — has been appointed director of nursing, Douglas Community Hospital, Roseburg, Oregon. Formerly she was head nurse in the maternity ward at Douglas. Mrs. Foutz will replace Mrs. Louis Sauer, who resigned to go into private nursing.

Ira H. Goldberg — has been appointed executive director, Rest Haven Rehabilitation Hospital, Chicago. He was formerly assistant director, Louis A. Weiss Memorial Hospital, Chicago.

Col. Joe Raymond Henry — has been appointed commanding officer of the Air Force Base Hospital, Keesler Field, Miss. His previous assignment was command of the 659th Tactical Hospital, Tachikawa, Japan.

Mrs. Ila B. Honeycutt—has been chosen administrator, Kimble Hospital, Junction, Tex. She was formerly associated with a hospital at Del Rio, Tex.

Homer Horton, Jr. — has been named administrator, Greenville (Tex.) Community Hospital. He was formerly administrator, Calhoun County Memorial Hospital, Port Lavaca, Tex.

Mrs. Opal Hopkins — has been selected as director, nursing department, DeKalb General Hospital, now under construction at Decatur, Ga. The hospital is scheduled for opening in the spring of next year.

Peter S. Hutchinson — has been named assistant administrator, South Chicago Community Hospital, Chicago. He recently completed his administrative residency at Iowa Methodist Hospital, Des Moines, and holds a master's degree in hospital administration from the University of Chicago.

Raymond L. Ingraham—has been elected comptroller, Winter Park (Fla.) Memorial Hospital. His previous position was that of office manager.

Paul Kibby—has been appointed administrator, Quincy Valley Hospital, Quincy, Wash. He was formerly a nurse anesthetist at the hospital.

Norbert Lindskog—has been appointed evening administrator, Louis A. Weiss Memorial Hospital, Chicago, a newly created position. His duties will include all administrative responsibilities at the hospital from 3:30 p.m. until midnight.

S. James Lund—is new office manager, Good Samaritan Hospital, Portland, Ore. He succeeds **A. E. Brim**.

Mrs. John R. MacNeil—has been named director of nursing services at the new 56-bed Overlake Memorial Hospital, Bellevue, Wash. She formerly held the post of director of nurses, Riverton General Hospital, Seattle.

Yancy McCrea, Jr.—has been appointed administrator, McCamey (Tex.) Hospital.

Richard A. McFarland—is the new administrator, Flow Memorial Hospital, Denton, Texas. He was formerly assistant director, Barnes Hospital Medical Center, St. Louis, Mo.

Joseph F. Morrison, Jr.—has been appointed administratve assistant, Baptist Hospital of Southeast Texas, Beaumont.

Mother Hildegarde, R.S.M. — has been appointed administrator, Mercy Hospital-Street Memorial, Vicksburg, Miss. The position was previously held by **Sister M. Amadeus**.

Bertrand B. Nutter — has accepted appointment as administrator, Groton (Mass.) Community Hospital, succeeding **Muriel Wescott**. He was formerly administrator, Salem (Mass.) Hospital.

Alfred Paulson — will be general administrator of the planned 100-bed Hawthorne Convalescent Home to be constructed at Medford, Ore. The facility is expected

to be completed by the summer of 1961.

Mr. Paulson is presently administrator, Ashland (Ore.) General Hospital.

Fred W. Poe—has resigned as administrator, Winters Municipal Hospital, Winters, Tex. to accept a position in Midland, Tex.

Hasty W. Riddle—has been named executive director, Kentucky Hospital Association, Louisville. He is a retired Lieutenant Colonel, U.S. Army and has been an instructor in hospital administration, Army Medical Service School, Fort Sam Houston, Tex.

Sister Anne Lucy – has been appointed administrator, Our Lady of Lourdes Hospital, Pasco, Wash., succeeding **Sister Mary Stephen,** who has been transferred to Mount St. Mary's College, Los Angeles, Calif.

Sister Anne Lucy was formerly administrator, Daniel Freeman Hospital, Inglewood, Calif.

Sister Mary Venarda, R.S.M. – is new administrator, Mercy Hospital, Chicago. She succeeds **Sister Mary Michael, R.S.M.** Sister Venarda was formerly administrator, Mercy Hospital, Davenport, Iowa.

Sister Philomena—has been named business manager, Hotel Dieu Hospital, El Paso.

Sister Rita Rose, O.P. – has been designated administrator, St. Dominic-Jackson Memorial Hospital, Jackson, Miss., succeeding **Sister M. Teresita.**

Craig S. Slater – has been elected administrator, Beverly (Mass.) Hospital. He was formerly assistant administrator.

Mr. Slater succeeds **Mae M. Bartley,** who resigned after serving the hospital for 35 years, of which 27 were in the position of administrator.

Howard Smith – has been appointed administrator, Grandview Hospital, Edinburg, Tex., succeeding **Fred Champion.**

Mrs. Cecile Tracy Spry, R.N., F.A.C.H.A.—has retired after 30 years' service as administrator, General Hospital of Everett (Wash.). She will be succeeded by **Alfred Muller, Jr.,** who has been the hospital's assistant administrator since 1957.

Cecile Stephenson – has been appointed director, Methodist Hospital of Dallas School of Nursing.

Donald M. Stewart – has been named administrative assistant, Methodist Hospital of Dallas. He received his master's degree in hospital administration at Northwestern University in June and had served his residency at Methodist Hospital of Dallas.

C. Evans Tyson – is the new administrator, Laird's Hospital, Union, Miss., succeeding **Earl Laird, M.D.,** who will devote full time to medical practice. Mr. Tyson was formerly credit manager, Riley's Hospital, Meridian, Miss.

William D. Voorhees, Jr., M.D. – has been appointed superintendent, Northern State Hospital, Sedro Woolley, Wash. He succeeds **Charles H. Jones, M.D.,** who resigned to become director of Butler Psychiatric Hospital, Providence, R. I.

Prior to his new appointment, Dr. Voorhees was director of outpatient services at Western State Hospital, Fort Steilacoom, Wash.

Bernard P. Widmann, M.D. – has retired as head of the department of radiology, Philadelphia General Hospital, a position he has held for 32 years. He will be succeeded by **George T. Wohl, M.D.,** presently director of radiology and radioisotope service, VA Hospital, Philadelphia.

VA Appointments

Samuel C. Kaim, M.D. – has been named chief of psychiatric research for the VA and will be attached to the VA central office, Washington, D.C. He was formerly chief of inpatient psychiatry and neurology, VA hospital, Coral Gables, Fla., and a clinical assistant professor of neurology, University of Miami.

Robert I. McClaughry – has been appointed director of medical education service for the VA. He is a former assistant dean of Wayne University College of Medicine, Detroit, and for the past year served as director of the National Academy of Sciences-National Research Council staff engaged in reviewing the medical research program of the VA.

Claire N. Vernier, Ph. D.—has been appointed acting director of a new VA staff element, for application of automatic data processing in medical and dental research.

Dr. Vernier was formerly chief of the central laboratory for cooperative psychological research, at the VA hospital, Baltimore.

New Officers

Lynn W. Bertholf, R. N. – is the new executive director, Tenneessee Nurses Association, Nashville.

Robert A. Kimbrough, Jr., M.D.—has assumed duties in the newly created post of medical director of the American College of Obstetricians and Gynecologists, Chicago. His responsibilities will include the coordination of the activities of the College and of its committees which have to do with medical problems and policies.

Dr. Kimbrough was formerly in active practice in Philadelphia, where he was director of the division of OB and gynecology, Pennsylvania Hospital.

Nicholas J. Eastman, M.D., Baltimore, Md., has been chosen president-elect of the College, filling the vacancy created by the death of **Herbert E. Schmitz, M.D.,** Chicago.

New officers of the American Society of Anesthesiologists, elected at the recent annual meeting held in New York, are **Joseph E. Remlinger, Jr., M.D.,** Wilmette, Ill., president; **Forrest E. Lefflngwell, M.D., Pasadena, Calif.,** president-elect; **Douglas H. Batten, M.D.,** San Diego, Calif., first vice-president; **Robert L. Patterson, M.D.,** Pittsburgh, Pa., secretary; and **Albert M. Betcher, M.D.,** New York, treasurer.

Rheumatic Fever Vaccine Experiments Promising

A new experimental vaccine has been given to ten children who had recovered from strep sore throat, an infection which may trigger rheumatic fever. Encouraging results of the vaccinations were reported to the American Society for Clinical Investigation, by the Northwestern University scientists who tested the vaccine.

The vaccine is prepared from the cell walls of type 12 strep, and was given in three to four small booster shots to children who had had strep infections two years previously. At the time of vaccination, none of the children had shown strep antibody in their blood.

In all ten patients, vaccination was followed by a level of antibody as high as that following natural infection, according to Drs. Gene H. Stollerman of the American Heart Association's council on rheumatic fever and congenital heart disease; Elizabeth V. Potter, and Alan C. Siegel, a grantee of the Chicago Heart Association.

Hospital Administration Librarians Confer

Librarians serving the field of hospital administration met recently under the auspices of the program in hospital administration, University of Michigan, to discuss a variety of topics. Paul Wasserman, school of business and public adminstration, Cornell University, directed the informal program. The following resolutions were made:

1) Affirmation of importance of the library in hospital administration programs and proposal that directors of such programs be encouraged to seek support of university and other facilities to help accelerate library expansion and development to support the programs.

2) That the American Hospital Association Library should be advised of the need for a monthly indexing service to centralize periodical indexing.

3) That library personnel should be brought into research processes at the planning stage to facilitate research designs and that instruction in the use of the library's bibliographic apparatus as part of the hospital administration teaching program be provided.

4) That an organizational affiliation for librarians of hospital administration be formed with the six attending members from the U.S. and Canada as its nucleus.

5) That a crucial need in the field is a workable subject heading schedule more closely related to the theoretical and academic attitudes of the university programs as contrasted with needs of the practitioners.

25-Ton Radiation Counter Installed in VA Center

A human body radiation counter has been installed in the Veterans Administration center in Los Angeles. The 25-ton steel room makes possible measurement of the amount of radiation present in the body from fallout, medical dosage, handling of radioactive materials, or other sources.

Dr. William H. Blahd, chief of radioisotope service at the center, said the counter will be used in diagnosis and medical research and will be an important resource for civil defense.

The chamber, 6 x 6 x 4 feet in size, is made of 5 laminated 1-inch sheets of steel, plus 1/16-inch lead lining. In testing, the patient sits in the chamber while an extremely sensitive detector mounted over him transmits the radiation measurement to an analyzer mounted on the outside of the chamber.

The counter was designed by Dr. Blahd and Dr. Benedict Cassen, VA radioisotope consultant and clinical professor of biophysics and nuclear medicine at UCLA.

Enrollment Increases In Nursing Schools

Admissions to schools of practical nursing increased an estimated 2,000 in 1959 over the estimated 21,500 of 1958—while schools of professional nursing enrolled approximately 47,797 students compared with 47,351 in 1958, according to a recent National League for Nursing announcement.

As in previous years, diploma programs of professional nursing schools in hospital and independent schools continued to enroll the most new students—37,686 or 81.4 percent of the total. College programs offering a bachelor's degree in nursing admitted 15.7 percent of the total, while associate degree programs in junior and community colleges admitted 1,266 or 2.8 percent. Percentages also rose slightly for baccalaureate and associate degree programs.

Successful Prosthesis of Entire Aortic Valve

The third successful prosthesis in a 3-week period of an entire aortic valve has been made by a heart surgery team headed by Earle B. Kay, M.D., at St. Vincent Charity Hospital, Cleveland. The patients are all males, ages 18, 23 and 39.

A regurgitative valve and a stenotic valve were replaced with plastic aortic tricuspids of knitted Teflon partially coated with polyurethane, and a rheumatic valve was replaced with Ivalon, to which they switched after laboratory tests gave evidence of less thrombus formation, less fibrin deposition and promise of more satisfactory tissue coverage.

Dr. Kay, chief, thoracic surgery and cardiovascular surgery, and director, cardiovascular research at St. Vincent's, performed the operations; Akio Suzuki, M.D., surgical resident, made the valves and Henry Zimmerman, M.D., evaluated the patients for operation.

Post-operative recovery has been benign. Dr. Kay said that success depends on complete correction of the insufficient valve, proper myocardial support, management during and after perfusion, and the decision to operate while the patient's condition is still strong enough.

For myocardial management he used a combination of cardiac arrest by coronary perfusion of oxygenated ice-cold Ringer's solution for the 10- to 15-minute period till coronary cannulation was established, and direct coronary perfusion with slightly hypothermic blood (30°–32°) during insertion of the new valve. He believes that success is due to the simplicity of the substitute valve which can be cut at the time of operation to meet individual requirements.

PIONEER on Every Hospital Hand

In addition to its long-life line of Rollpruf Surgical Gloves, Pioneer makes other glove styles, weights and materials to protect every hand at work in your hospital. Your Pioneer Glove Expert can show you new ways to achieve maximum glove economy by using the complete Pioneer Hospital Glove Line. The coupon at right entitles your hospital to a free Glove Handling Analysis by Pioneer experts, to insure the efficiency of your glove usage.

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For further information see postcard opposite page 126.

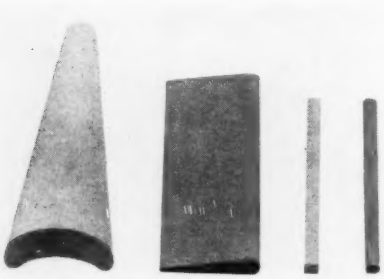
HOSPITAL Topics

BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 126.

400. Walking tricycle

The Schede Walking Tricycle, for treatment in congenital hip dislocations, flat feet, post-operative leg osteotomies, and polio, is now available in the United States for the first time. Because of the play approach incorporated into the design of the unit, the tricycle is said to receive maximum cooperation, with proportional benefits, from young patients. The seat, 13″ from the floor, adjusts to 17″; the range of abduction is 90° to 140° for each leg. Available without charge upon request is a reprint of a technical article, *The Three-Wheel Device in Orthopedic Surgery*, by Von Prof. Dr. Fr. Schede. Orthopedic Equipment Company, Bourbon, Ind.

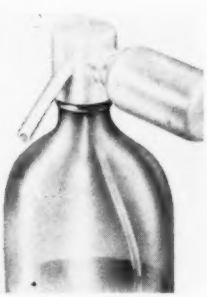


401. Instrument hones

Instrument hones, consisting of a gouge stone, wedge slip stone, square India stone and a round India stone, are available as a set of four, or may be ordered individually. Zimmer Manufacturing Co., Warsaw, Ind.

402. Dispenser

A squeeze of the bulb starts new polyethylene dispenser, a touch of the valve stops it, without drip. Pump body is fitted with syphon, spout, and 4-oz. squeeze bottle. Delivers liquids at a rate up to 1000 ml per minute. General Scientific Equipment Co., Limekiln Pike & Williams Ave., Phila. 50, Pa.



403. Mirror

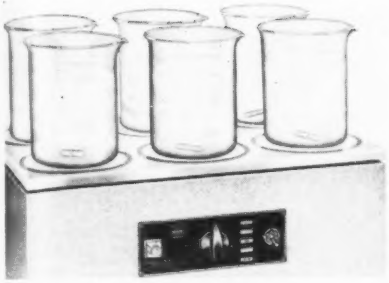
New plating process, Mirror-Tone, permits unconditional guarantee that heads of these professional mirrors will never oxidize, discolor, or peel, regardless of sterilization method: autoclaving, boiling, dry heat or cold sterilization. Mouth and laryngeal mirrors are enameled on back and side of glass to eliminate raw edges, infiltration of water, steam, etc. Each head is individually packed in sealed carton for maximum protection. Mirror-Tech Manufacturing Co., 111 Cedar St., New Rochelle, N. Y.

404. Admittance chair

Sturdy new wheelchair specifically designed for use as a patient admittance chair, freeing other wheelchairs for ward use. Patient's luggage is place on rack, out of the way of patient and attendant. Over-all width, 22″; folds to 8″ for easy storage. Folding, adjustable footrests; safety brakes; hard rubber semi-penumatic tires. Plastic reinforced upholstery provides even, firm support. American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.

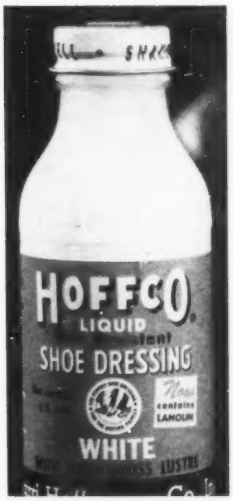
405. Disposable draperies

Draperies of fire-retardant, sun-resistant, nonwoven bonded rayon fabric are available in solid pastels and nine floral patterns on white grounds. Economical enough to be disposable, yet can give years of service. No washing is needed; after brushing or vacuuming to remove dust, can be refreshed with warm iron. Come fully hemmed and headed to be hung, 72″ wide and 90″ long. For cafe curtains, the length cut from the bottom may be used as the valance. Hemming is not necessary as the cut edges do not ravel. Busse Hospital Products, 64 West 8th St., New York, N. Y.



406. Magnetic stirrer
New magnetic stirrer capable of mixing and stirring solutions in as many as six vessels at one time solves the problem of stirring several vessels simultaneously at the exact same speeds. The Multi-Magnestir can stir up to six vessels, each of 1000 ml. capacity, at predetermined speeds for indefinite periods of time, and give identical agitation for each vessel. The single unit construction, of heavy-gauge aluminum, reduces bench space up to 50 percent; measures 18"x12"x 7". The 1/20 h.p. motor is lubricated for life; Ohmite rheostat gives variable stirring action from slow mixing to high-speed agitation. Labline, Inc., 3070 W. Grand Ave., Chicago 22, Ill.

407. Betadine aerosol spray
A most effective antiseptic and germicidal agent in spray form for treatment of extensive third-degree burns. Betadine's active ingredient is povidone-iodine (a complex which retains microbicial action only of iodine, while eliminating drawbacks of tincture of iodine). The spray, by preventing and controlling any infection, provides a bacteria-free environment unsuitable for the proliferation of pathogenic microorganisms, and burns are left remarkably free of noxious odors. Can be applied directly to burned or denuded areas without fear of smarting or irritation. There is no systemic absorption, and product is acceptable for use even on severely burned children. Tailby-Nason Co., Inc., 6501 Empire State Bldg., New York 1, N. Y.



408. Shoe white
Liquid shoe white, Hoffco, can be buffed to a high lustre on smooth leather after drying; absolutely will not rub off. Dressing also available for white buck; plus 40 colors, a suede spray, and patent leather renewer. All non-toxic. Harri Hoffman Co., Inc., 2018 E. Thomas Ave., Milwaukee 11, Wis.

409. Surgent
Hexachlorophene liquid soap U.S.P. incorporates bacteria-killing action, yet leaves skin gentle and soft due to high cold cream content. Economical, has fine, pink creamy lather. Any size, up to 55-gal. drum. Hysan Products, 932 W. 38th Place, Chicago 9, Ill.

410. Disposable needle
Sharp-et, disposable hypodermic needle, includes the Sterapac cartridge, a polyethylene container with bacteriostatic properties which renders cartridge and contents impervious to most bacterial and fungal attack, even after prolonged storage. Foil-seal on the cartridge guarantees the sterility of the needle. When the cartridge is opened, needle is ready for immediate use. The cartridge top is discarded, the lower section may be used as a wrench to engage or disengage the needle. With cartridge attached, needle is protected almost to point of contact. Needle has non-toxic metal hub and sharp, drag-free polished point. Cartridge top is color-coded for ready identification. Randall Faichney Corp., 299 Marginal St., Boston 28, Mass.

411. Emergency splint
So simple that an untrained attendant can apply it in 39 seconds, new splint combines shaped aluminum half-sections with built-in padding and traction. It is fastened by three web straps to provide moderate, uniform compression to control bleeding and swelling. All x-ray work can be done without removing the splints. Corrosion-resistant, the splints can be readily stored. Stryker Orthopedic Frame Co., 420 Alcoyt St., Kalamazoo, Mich.

412. Test tube rack
New S-shaped test tube racks have no joints, no welded or soldered edges to pull apart; do not crack, break, split, sag, or swell; resist all common laboratory corrosives; see service in ovens and autoclaves without warping. Nest for storage. All aluminum, with eight holes 1" in diameter; 9" long, 2¾" wide, and 2⅜" high. Fisher Scientific Co., 444 Fisher Bldg., Pittsburgh 19, Pa.

For further information see postcard opposite page 126.

413. Wall-ceiling cleaner

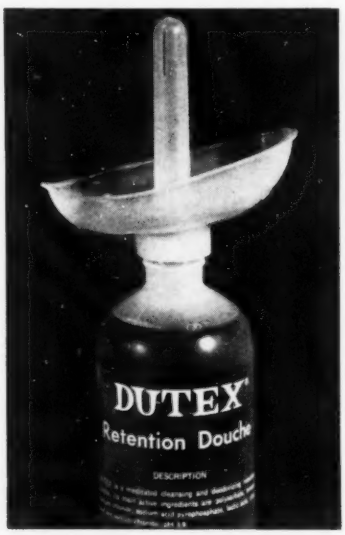
New wall and ceiling cleaning machine cleans 100 square feet in six minutes. Simple to operate, noiseless, dripless. Consists of dual solution tanks, 18″ high by 14″ in diameter, of stainless steel, with 2-gal. capacity; 40′ long-wearing, kinkless rubber hose; two 6″x12″ rustproof magnesium trowels; 6″x12″ dryer. Machine operates without electricity. Available from dealers on a rental basis. Alan Manufacturing Co., 4350 N. Elston Ave., Chicago 41, Ill.

414. Safetrode

New device eliminates possibility of burns resulting from improper electrical contact with metallic indifferent electrode plates in neurosurgery. The large flat condenser, 25½″ x 15½″, molded in autoclavable neoprene, matches the capacity of the patient's body and induces energy into the patient. Requires no jellies or contours. It is simply placed on the operating table in a position approximating the trunk of the body, with the sterile sheet draped over it. Patient can be moved at will to any position. Fits any electrosurgery unit. Birtcher Corp., 4371 Valley Blvd., Los Angeles 32, Calif.

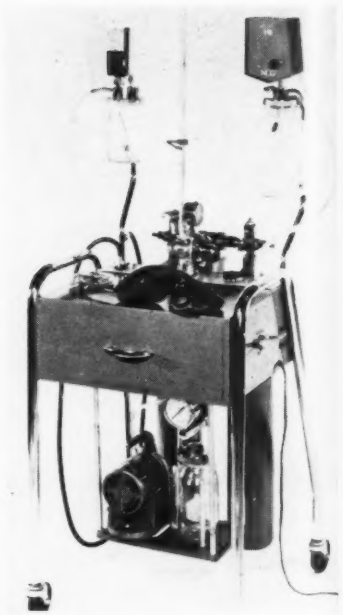
415. Single-dose vial

Dosettes, single-dose vials, of sodium phenobarbital, vitamin B-12, Heparin, and d-Pantothenyl alcohol, are now available. Convenient, ready-to-use, vials provide economies in time and effort for on-the-floor use. Each contains exact single dose, eliminating measuring, spillage and breakage, and inventory problems. Free trial supply of sodium phenobarbital available to hospitals. Intra Products, Dayton, O.



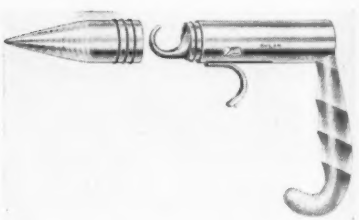
416. Disposable douche

New Dutex incorporates the concept of the retention principle, and eliminates danger of cross infection, provides greater therapeutic effectiveness in treatment of common vaginal disorders, saves time, is economical to use. Bottle may be filled with solution prescribed by doctor, or contents of premeasured Dutex packet may be used. May be used with or without safety valve. With valve in place, fluid enters vaginal cavity slowly, cannot flow backwards, and provides treatment of infections. With valve removed, douche can be used for cleansing purposes. Tests proved that even maximum pressure, no trace of radiopaque fluid was found to invade the cervical canal, uterine, or peritoneal cavity; no irritation. Effective for routine douching in feminine hygiene; may be used safely during menstration. Emanem Laboratories, Inc., 739 E. 87th Place, Chicago 19, Ill.



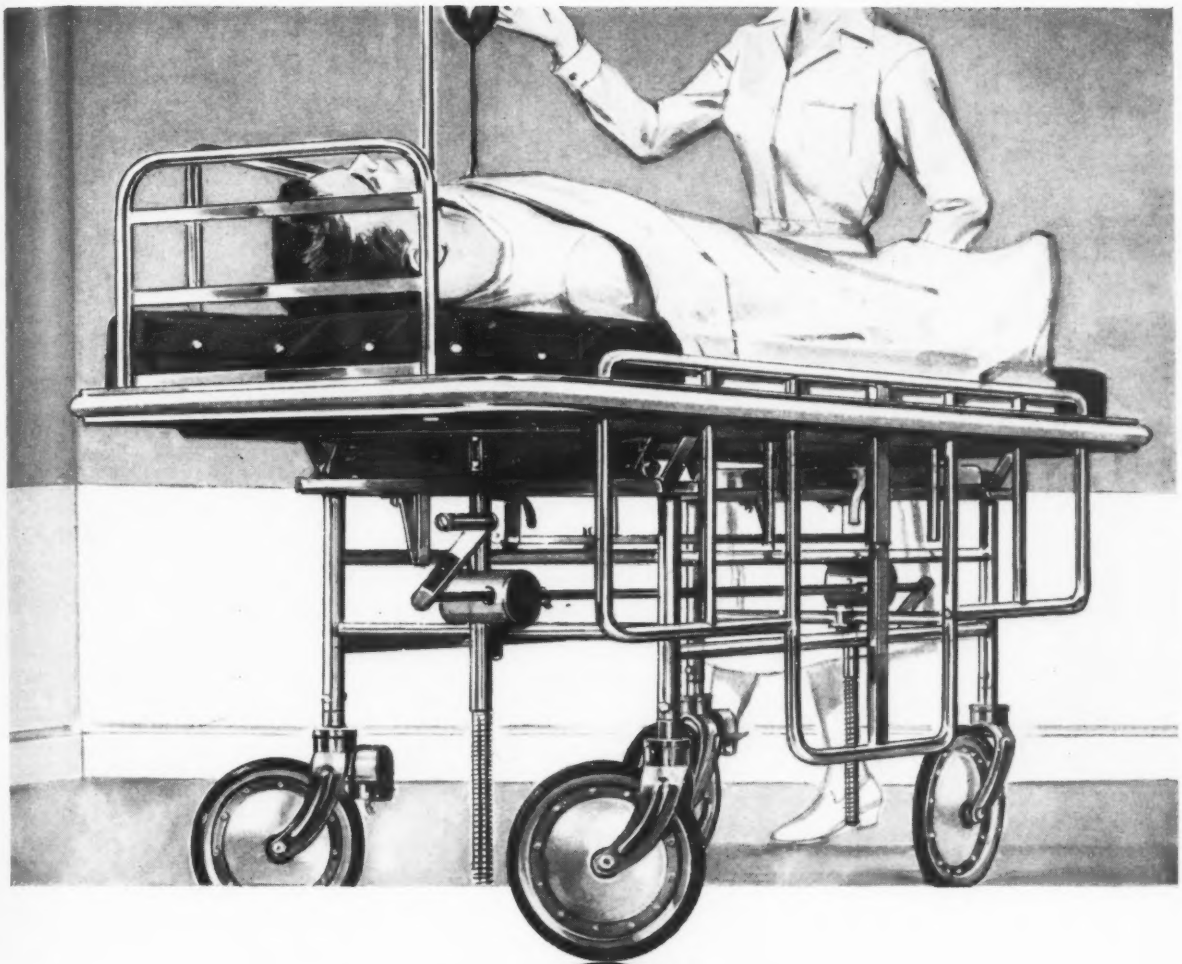
417. Emergency cart

New cart enables nurse to supply oxygen, suction or air more quickly to a patient, before arrival of a therapist or doctor. Unit is rubber-wheeled metal table with drawer; equipped with oxygen regulator, a fast-starting, positive-action pump providing compressed air or suction, an oxygen regulator and yoke headers equipped with check valves so that "E" cylinders may be replaced during use. National Cylinder Gas Division, Chemetron Corp., 840 N. Michigan Ave., Chicago 11, Ill.



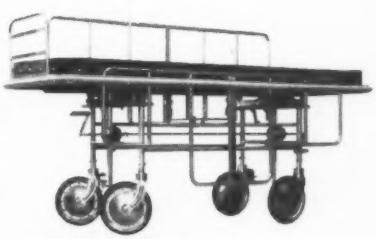
418. Umbilical cord tier

New automatic Gravlee Gun not only ties the umbilical cord easily, quickly and very securely, but prevents contamination from operator's hands. After placing cord in hook, it is litigated with a piece of latex rubber tubing simply by pulling the gun trigger. Entire procedure takes only 20 seconds. Consists of two pieces of stainless steel tubing, two springs, a hook, trigger, and a conical metal loader. Gun may be sterilized by any of the conventional methods. J. Sklar Manufacturing Co., Long Island City, N. Y.



from the ground UP Colson® builds it better...

Colson starts with the first essential, mobility, and begins building quality there with Colson wheels and casters. Seventy-five years of experience go into putting together the *total* unit. Literally from the ground up, Colson builds it better, supplying the complete product and a complete line of hospital equipment. From casters to completion, each part of Colson's P.A. Stretcher is made with the careful precision that has made Colson famous for long-lasting quality. In the long run, quality costs less. Buy once, buy the best . . . Colson.



COLSON'S 75th YEAR OF PROGRESS

75 years of experience in supplying field-tested equipment and casters to industry and institutions. Millions of satisfied customers know and respect the name COLSON . . . synonym for quality.

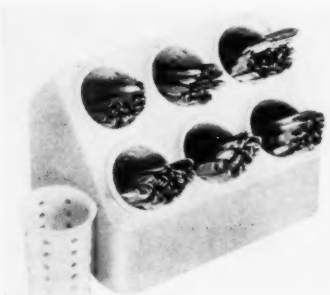
ANNOUNCING TWO MAJOR IMPROVEMENTS IN COLSON'S FINE P.A. STRETCHER

Already preferred for its simple design, ease of operation, and patient-comfort, Colson adds two important improvements. The wheel base is 16% wider, providing safety and stability during patient transfer, tilting and elevating. Safety side rails now have rounded corners. Other features included are: square-socket IV rods; wide track wheels; head rest with double horizontal bars; full 80-inch litter, and optional four-inch air foam pad for ultimate patient-comfort. Dozens of accessories available to create the perfectly equipped comfortable P.A. Stretcher. Write today for a free illustrated catalog showing the full line of quality Colson stretchers. Colson has one for every requirement.

THE COLSON CORPORATION 7 S. Dearborn Street
Plants in: Jonesboro, Ark.; Sommerville, Mass. and Elyria, Ohio CHICAGO, ILLINOIS

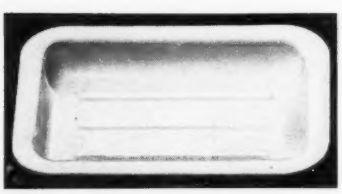
419. Glass joint

New Pyrex glass joint for laboratory use provides greaseless, vacumm-tight seal. By eliminating need for greasing, the O-ring joint eliminates source of possible contamination. Can be quickly and easily assembled and dismantled, is engineered for such applications as high temperature atmospheric and vacuum distillations, as well as infrared and mass spectrometer analysis. Standard size, and can be used for absolute pressures as low as 0.2 mm. and temperatures as high as 300°C at these pressures. Corning Glass Works, Corning, N. Y.



420. Silv-O-Tainer

Marlex plastic, virtually indestructible, is used in new holder for flatware. Lightweight, easy to handle and simple to clean. Available in both counter-top and under-counter styles, unit is strong enough to support 300 lbs. and capable of holding half-gross each of knives, forks, and several gross of spoons. Unaffected by food acids or alkalis; will not stain, corrode, or pick up food odors. Bloomfield Industries, Inc., 4546 W. 47th St., Chicago 32, Ill.



421. Miniature soap dish

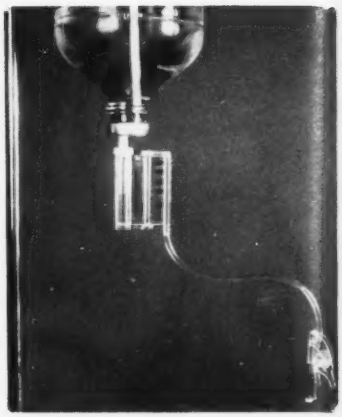
With a maximum base of 2½"x1⅝", dish is valuable for use in limited space and in short-stay transient areas. Economical, unbreakable, fully autoclavable, stain- and chemical-resistant. Zylon Products, Inc., 40 Church St., Pawtucket, R. I.

422. Stomach irrigation tube

Two-way stomach irrigation tube of 16 French polyvinyl permits gastric lavage and gavage to be performed simultaneously and continuously. Irrigating solution enters the stomach in a safe, gradual flow while, through a separate lumen, washings are withdrawn by automatic suction. Process eliminates danger of sudden blockage caused by stomach collapse; prevents drip and suction materials from mixing. Nursing supervision is required only to replenish solution and empty bottles — once every eight or 10 hours. Tube is tasteless, odorless, non-toxic and packaged for immediate use. Especially useful in cases of postoperative vomiting, partial intestinal obstruction, barbiturate or food poisoning, etc. Clay-Adams, Inc., 141 East 25th St., New York 10, N. Y.

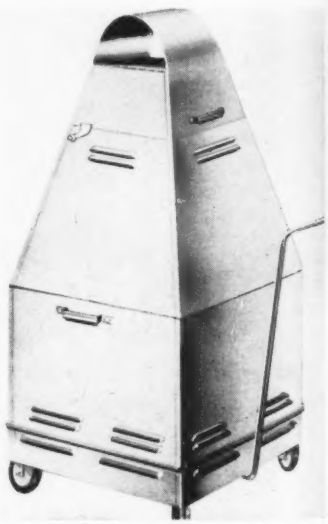
423. Incontinent pad

New Curity Poly-Incontinent pad offers stronger, more comfortable protection to the patient. Real fabric yarns give the top sheet a smooth cotton softness without any loss of wet strength. Improved bottom sheet is made of pure polyethylene, 100 percent waterproof. Rattling and wrinkling, along with sharp edges, are eliminated. Seven piles of exclusive cellucotton assure highest absorbency available. The Kendall Co., Bauer & Black Division, 309 W. Jackson Blvd., Chicago 6, Ill.



424. Pak-O-Meter

New plastic intravenous set offers a new degree of accuracy via unique metering chamber which shows at a glance the flow rate in cc's per hour, and a precision regulating device for setting and maintaining constant flow rate. Three models to fit the three major types of fluid found in routine parenteral solution containers. Selection of two flow rates: one with settings from 70 to 500 cc's per hour, the other with settings from five to 70 cc's per hour. C. R. Bard, Inc., 490 Morris Ave., Summit, N. J.



425. Incinerator-trash receptacle

New combination incinerator-receptacle eliminates hauling and handling of trash; permits burning safely outdoors within 10 feet of buildings, and may be used inside or outside as trash receptacle. With wheels and handle, mobile unit can be moved inside at night as precaution. Large hinged hood for fire protection and easy loading; burners minimize smoke and smell, require no watching. The Alsto Co., 4007 Detroit Ave., Cleveland 13, O.

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with skillful guidance

A MATCHLESS COMBINATION

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THE SAME *Safe* PACKAGE

B-P Sterile Blades . . . always assuring cutting efficiency at its best . . . NOW packaged in a choice of steel to meet your requirements.

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in the puncture-resistant *easily* opened package

CARBON

SHARP at equal hardness—carbon holds its cutting edge longer.

RIGID the 'RIB'—exclusive with the B-P RIB-BACK carbon steel blade gives extra rigidity. Rolling a 'rib' on stainless is difficult and too costly.

SAFE danger of breakage during surgery is minimized—carbon has a greater degree of toughness without embrittlement.

STAINLESS

CORROSION RESISTANT will not corrode when subjected to a reasonable period of thermal sterilization.

ECONOMICAL resterilization of exposed but unused blades eliminates 'discards'—saves costs.

TIME-SAVING may be attached to handles for emergency use in put-ups involving cardiac arrest, tracheotomy, paracentesis, or wherever preassembly is necessary.

BARD-PARKER BLADES are available:

Sterile
- B-P RIB-BACK carbon steel (individual package)
- B-P stainless steel (individual package)

Non-Sterile
- B-P RIB-BACK carbon steel (6 of one size per package)
- B-P RACK-PACK RIB-BACK carbon steel (gross and half gross units of one size)

B-P • RIB-BACK • IT'S SHARP are trademarks

BPI-60

B-P
BARD-PARKER COMPANY, INC.
DANBURY, CONNECTICUT
A DIVISION OF BECTON, DICKINSON AND COMPANY

426. Stethoscope

New Harvey-Cefaly stethoscope was developed when it became apparent that three, rather than two, chest pieces were necessary to most accurately listen to heart. Chest piece with larger diaphragm incorporates circular convex ridges which better detect and relay low and high frequency sounds, third heart sounds and diastolic rumbles. Bell chest piece is useful in fitting in smaller areas such as between ribs, supraclavicular area of the neck, and for infants and children. Chest pieces are mounted on a turret-head. In a fraction of a second each chest piece is easily rotated into position to focus on the most suitable auscultatory range. Overseas Service Corp., 1209 Dupont Circle Bldg., Washington 6, D. C.

427. Hemoccult

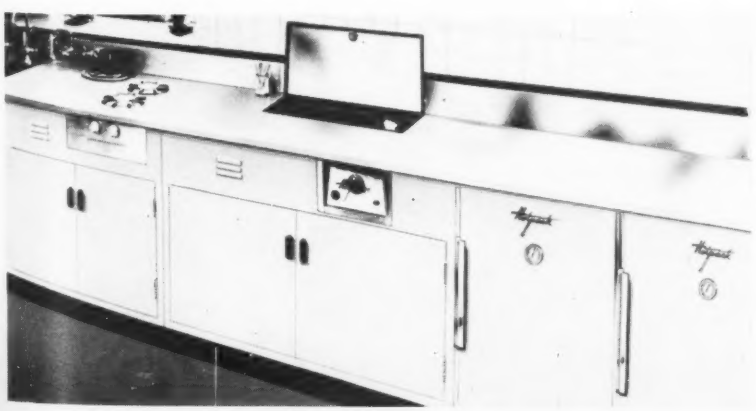
New diagnostic aid for detection of occult blood in feces and urine is a simple, one-minute test. Features special, pure electrophoresis filter paper impregnated with guaiac gum which remains stable indefinitely when protected from direct sunlight, ultra-violet light or strong heat. (In the past, guaiac gum has been used primarily in relatively unstable form in alcoholic solution as an indicator.) A 100" long strip in a plastic dispenser, and a special developer solution is also provided to render rapid definite results. Each kit will perform 100 tests. Schieffelin & Co., 30 Cooper Square, New York 3, N. Y.

428. Aeropedic mattress pad

New product is especially engineered to give comfort and relief to those suffering from bed-rest problems without the necessity of a mechanical device. The slightest movement of the user causes air to move through the air tubes. This soothing and sleep-inducing action overcomes restlessness and loss of sleep; is beneficial to those who are not necessarily bed patients. Used over any mattress, it provides a comfortable bed by suspending the user on a soft cushion of low-pressure air which conforms gently to the body. Howard Sales Co., P. O. Box 5113, Pasadena, Calif.

429. Radioactivity-measuring device

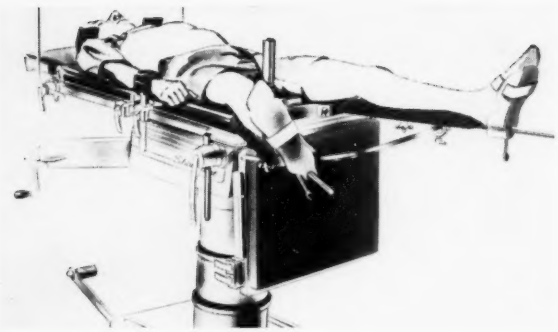
New Picker Magnascaler is designed to meet the most rigid standards of the research laboratory as well as routine requirements of clinical use. Can collect more than 600,000 counts per minute with accuracy in excess of 99 percent, has an extremely precise discriminator and will not overcount due to pulse distortion. Can be used with scintillation detectors, Geiger tubes, and proportional counters with pre-amplifiers. Has 11 pre-set time positions for clinical use; 11 pre-set count positions for pre-selecting statistical error. Can be combined with automatic sample changers and with printers to "read out" time and count data. Easy to use, it has very few controls and a start touch bar that resets the instrument automatically. The counts can be read direcly from six electronic decades. An odometer-type timer, accurate within 0.02 of one percent, is built in. Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y.



430. Space saver

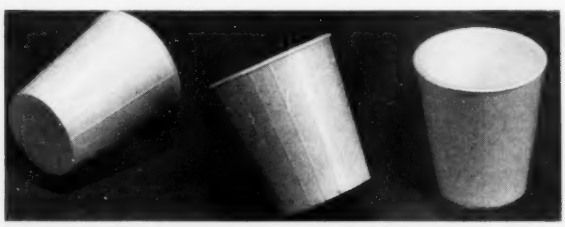
Designed to keep laboratories roomy, refrigerated, B.O.D. incubator and water bath fit snugly under counter or table top, yet remain accessible for instant service. Refrigerator and incubator in matching enameled cabinets with door thermometers. Hydraulic thermostats provide automatic control within ±0.5°C. Incubator temperature range: 5°C to 50°C. Water bath temperature range: 0°C to 60°C. (refrigerated); 30°C to 125°C . . . ±0.5°C. Bath features heaters beneath floor for even heat distribution. Stainless steel. Electric Hotpack Co., Inc., 5047-A Cottman St., Philadelphia 35, Pa.

For further information see postcard opposite page 126.



431. Leg traction unit

New unit offers correct support, traction and positioning for hip-pinning, bone-setting and for accurate x-ray examination. Leg platforms and footrests adjust to correct length along sturdy rod. Footrest also adjusts laterally, and is provided with a strap for holding foot firmly in position. Support rods fit into crutch sockets provided on the table and adjustment can be made with friction lock clamps. Use in conjunction with company's X-ray Permeable Top simplifies complete radiographic survey of hip, pelvis and femur without removing patient from the table. Shampaine Company, 1920 S. Jefferson Ave., St. Louis 4, Mo.

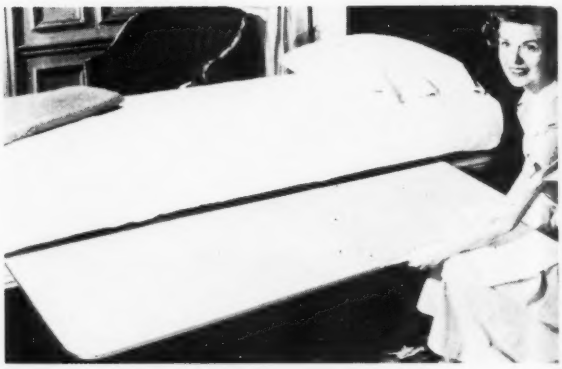


432. Disposable plastic cup

New foamed plastic disposable drinking cup for use with hot or cold drinks is molded of Pelaspan, expandable polystyrene beads. Foamed plastic acts as an insulator to maintain beverage temperature and allow handling comfort. One-piece molded construction eliminates seams, preventing leakage. The Thermokup won't get soggy or allow taste transfer to spoil the flavor of a beverage. Available in six-, eight- and 12-ounce size. Tight-fitting paper or transparent plastic lids are also available. Mid-West-Pak Corporation, Belvidere, Ill., and Crown Plastic Cup Company, Fort Worth, Tex.

433. Ambulance

Converted from an International Travelall, ambulance utilizes standard production body and chassis with special equipment. Formica laminated plastic surfacing, in platinum mahogany woodgrain, covers 120 square feet of the interior, including the driver-patient partition and fronts, sides, doors and interiors of equipment cabinets. The surfacing permits fast, complete hygienic cleaning with strong hospital disinfectants, withstands rugged ambulance service. Available in seven Travelall models. The ambulance conversion is made by R. J. States, Inc., Springfield, O.

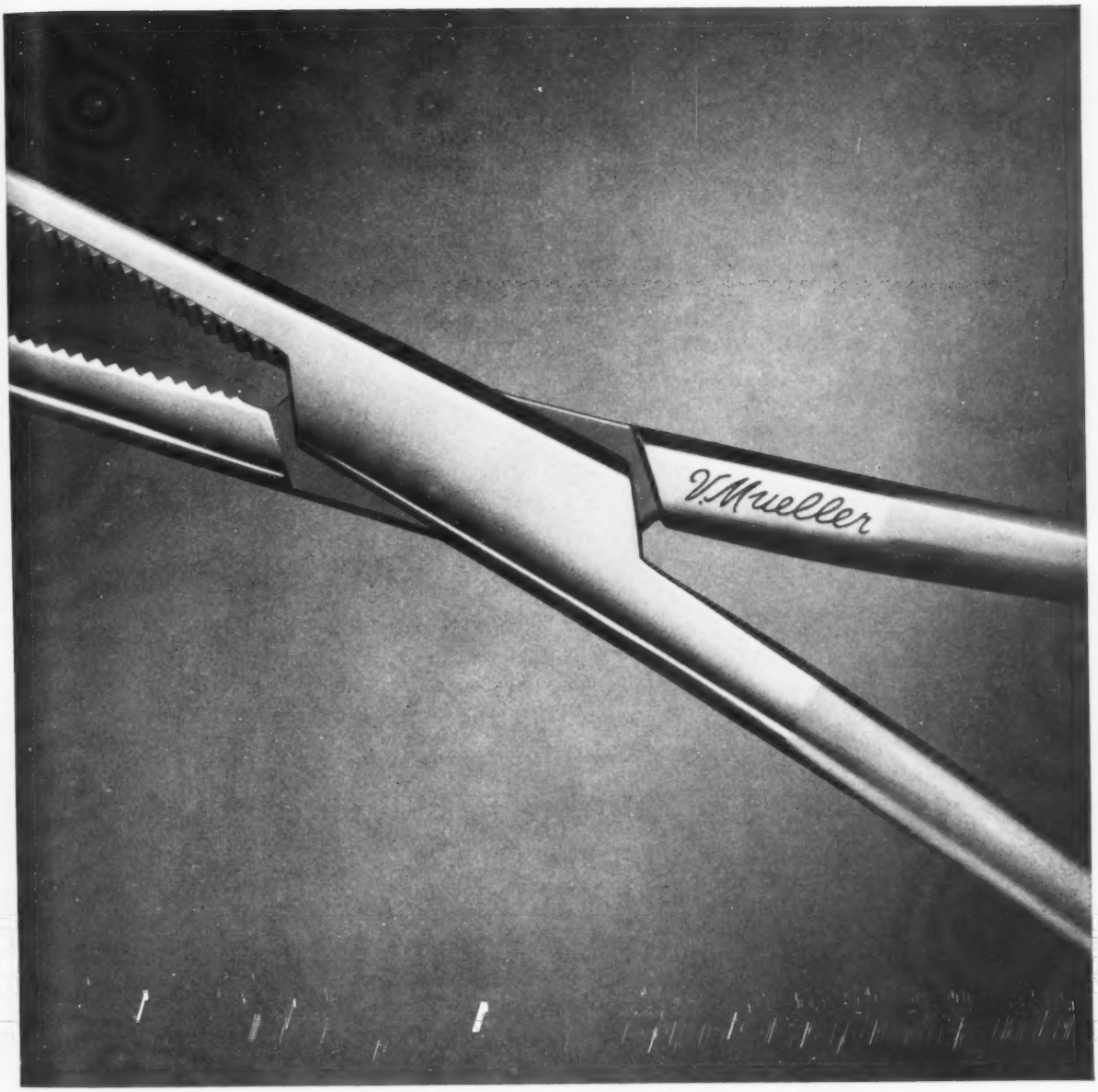


434. Bed board

New improved Tuco bed boards are designed to make a too-soft or sagging mattress into a posture protector with sleeping comfort. Eliminates "hammock" type of sleeping, in many cases the cause of spine misalignment, muscle strain, backache and incomplete rest. Made of mildew and moisture-proof top grade Upson laminated wood fibre board with permanently protected edges which will not snag bedding or injure hands. Surface is sanitized, plastic-coated, easy-to-clean, and highly durable. Available in sizes for all beds. Tuco Work Shops, Inc., Dept. BB-42, Lockport, N. Y.

435. Disposable syringe-needle

HYPOsterile disposable syringe and needle combination is now available in the three most popular styles – standard, tuberculin and insulin types. The complete syringe and needle unit, pre-sterilized and pre-packaged, is ready for immediate use, and guaranteed pyrogen-free. The double ring plunger operates in the full-sized barrel providing ample space for a full-capacity injection. Eliminates time previously devoted to cleaning syringes and resharpening needle, sorting and sterilization. Users are assured of the patient comfort of a factory sharp needle, plus knowledge that each injection will be a new syringe and needle, eliminating the possibility of cross-infection. Hypo Surgical Supply Corp., 11 Mercer St., New York, N. Y.



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For further information see postcard opposite page 126.

Spread an antiseptic umbrella aga

To help prevent staphylococcal infection, use* pHisoHex *not only in the operating room and the nursery— but everywhere throughout the hospital:

- for handwashing by all hospital personnel before and after caring for every patient
- for routine washing of newborn infants and their mothers' hands
- to wash patients ante and post partum
- to wash patients who have a communicable disease
- to wash patients who have an infective disease of the skin
- for surgeons' hand preparation
- to wash anesthesia equipment

TO REDUCE the spread of staphylococci and other organisms in hospitals, handwashing is "... *possibly the most important single control measure.*"[1] Just soap-and-water cleansing "... does not go far enough because it cannot be relied upon to kill the staphylococci."[2] But "when pHisoHex is used by nurses for handwashing, it is not possible to recover Staphylococcus pyogenes from their hands."[3] In addition, bacterial resistance to hexachlorophene does not develop.[4]

At the National Institutes of Health, the incidence of hospital cross infection in the Infectious and Parasitic Disease Service was practically eliminated when all hospital personnel washed with pHisoHex before and after caring for any patient.[5]

In hospital nurseries, routine use of pHisoHex for bathing infants as well as for routine handwashing by hospital nurses has helped prevent staphylococcal epidemics among newborn infants.[6,7]

Why is* pHisoHex *so often preferred? "The preparation appears to kill bacteria quickly, inhibits their growth, renders the skin's *surface* virtually sterile in many cases, forms an antibacterial film which kills fresh bacteria in the event of subsequent contamination after its use, saves time. . . . It is nonirritating, and it is hypoallergic."[8]

a against STAPHylococcal infections

with pHisoHex®

Antibacterial detergent with 3% hexachlorophene

1. Brown, J. W.: *J.A.M.A.* 116:1185, March 8, 1958. 2. Klarmann, E. G.: *Am. J. Pharm.* 129:42, Feb., 1957. 3. Hardyment, A. F.: Pediatric Clinics of North America, Philadelphia, W. B. Saunders Co., May, 1958, p. 287. 4. Gould, B. S.; Frigerio, N. A., and Hovanesian, J.: *Antibiotics & Chemother.* 7:457, Sept., 1957. 5. Benson, M. E.: *Am. J. Nursing* 57:1136, Sept., 1957. 6. Wysham, D. N., et al.: *New England J. Med.* 257:295, Aug. 15, 1957. 7. Baum, A. H., and Boles, R. D.: *J. Kansas M. Soc.* 60:248, June, 1959. 8. Medrek, T. F., and Litsky, W.: *Surg. Gynec. & Obst.* (Internat. Abstr. Surg.) 104:209, March, 1957.

Reinforce the antiseptic umbrella with anti-staphylococcal Zephiran® chloride, a powerful antiseptic and germicide that is nonirritating to the skin and mucous membranes—and ***Roccal,®*** a solution for general hospital sanitization and disinfection. Roccal rinsing renders textiles actively bacteriostatic against respiratory and wound discharge.

Write for or ask the Winthrop man for the leaflet, "Practical Pointers to Protect Your Hospital Against STAPHylococcal Infections."

Winthrop LABORATORIES New York 18, N. Y.

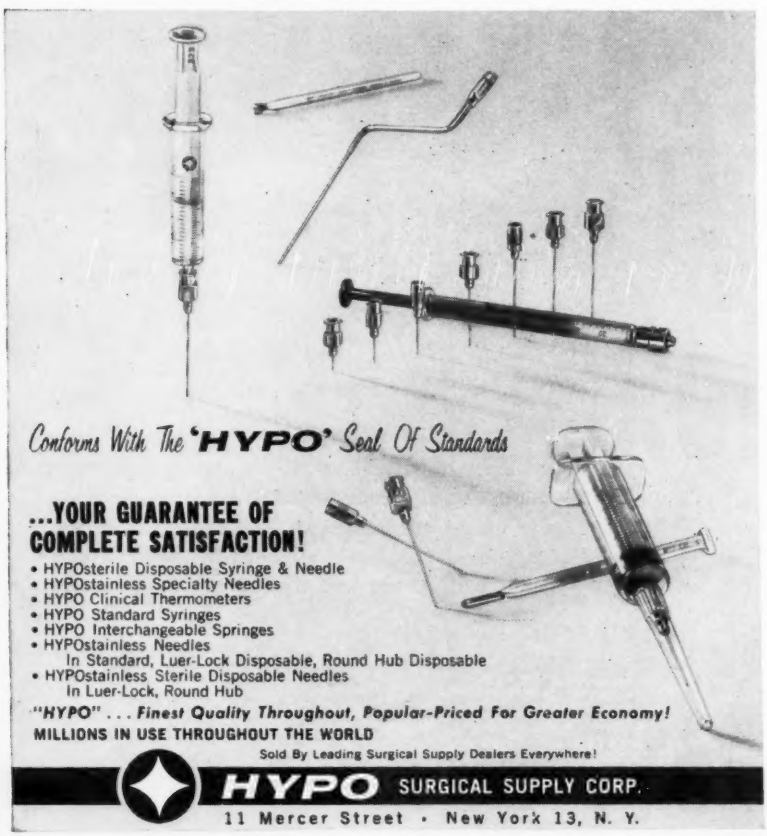
pHisoHex, Zephiran (brand of benzalkonium as chloride, refined), and Roccal (brand of benzalkonium chloride, technical), trademarks reg. U. S. Pat. Off. 1293-M

Films, New Literature

440. Modulatic boiler
New 200 h.p. drum modulatic boiler is described in Bulletin 4013. Includes complete specifications and describes such features as quick steaming ability, automatic modulation, compact size. Vapor Heating Corp., 80 E. Jackson Blvd., Chicago 4, Ill.

441. Film catalog
Revised 12-page catalog of 11 films on science, medicine and agriculture, including control of diseases in livestock, is available. With the exception of one, all the 16mm sound films are offered on loan basis. Included is *Life of the Molds,* one of 20 films representing the U.S. at last year's International Film Festival in Venice, Italy. Educational Services Dept., Chas. Pfizer & Co., Inc., 300 Second Ave., New York 17, N.Y.

442. Disposable Paper
The part that disposable paper products can play in handling rising admittance rate is suggested in new film slide, *The Most Important Building in Town.* Use of paper products for medication, food service, and other purposes is stressed in terms of sanitation, time and money savings, and noise reduction. Dixie Cup Division, American Can Co., 100 Park Ave., New York 17, N.Y.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MILLIONS IN USE THROUGHOUT THE WORLD
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11 Mercer Street • New York 13, N. Y.

443. Anatomy chart
New 12-page, profusely illustrated wall chart, 14½"x23½", with four-color cover, shows and identifies all the important bones of the body. In addition to human skeleton diagrams and nomenclature, separate pages illustrate and describe some of the firm's orthopedic equipment. Chart has metal edges and hangers, and will be mailed without charge to qualified readers. Education Dept., Ortheopedic Equipment Co., Bourbon, Ind.

444. Record books
New 20-page catalog of *Registers and Record Books* for hospitals, clinics and nursing homes is available. Described are patients' registers, recovery room registers, narcotic records, delivery room registers, operation schedule and record books. Illus. Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Ill.

445. Steam cooking
The 1960-61 edition of the 48-page booklet, *For Better Steaming,* is available. Included is information about the advantages of steam cooking, its uses, methods, cooking time for various foods, and guide to the selection of proper equipment. The Cleveland Range Co., 971 East 63rd St., Cleveland 3, O.

446. Parenteral feeding
New 44-page book, *Parenteral Nutrition,* gives basic information on parenteral feeding before, during and after surgery and in medical emergencies, and discusses patient's maximum tolerance for fluid and calorie requirements. A companion booklet, *Fluid and Electrolytes,* deals with minimum requirements in this factor. Illus. Abbott Laboratories, North Chicago, Ill.

447. Anticoagulants
To assist the physician in instructing his patients using anticoagulants, manufacturer offers a patient-aid booklet and "in case of emergency" patient card. Booklet details nature of the therapy, dosage schedule, importance of close cooperation with the physician, and lists symptoms of excessive effect or overdosage. Endo Laboratories, Richmond Hill 18, N.Y.

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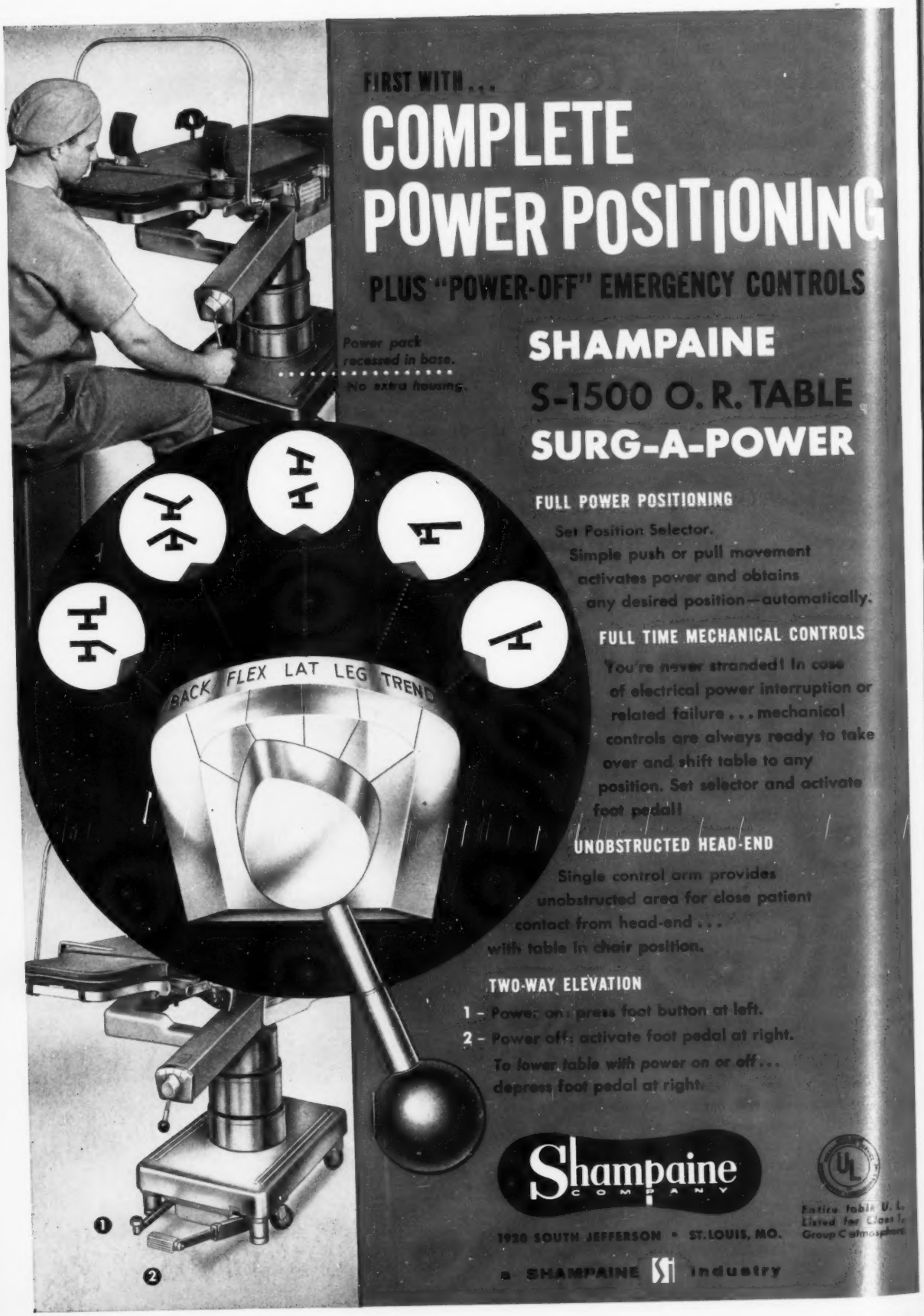
For further information see postcard opposite page 126.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BACK FLEX LAT LEG TREND
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Hospital Topics Book Corner

SIGERIST ON THE SOCIOLOGY OF MEDICINE, *edited by Milton I. Roemer, M.D.* MD Publications, 1960.

The late Henry E. Sigerist, M.D., was one of the greatest medical historians of all time. His extensive knowledge of languages and history has also allowed him to write an accurate record of social action.

Sigerist on the Sociology of Medicine, edited by Milton I. Roemer, M.D., of the Sloan School of Hospital Administration at Cornell University, is a collection of 31 essays from the late historian's abundant work. Twenty-eight of these have been previously published, two are from manuscripts found among the Sigerist papers, and one is derived from an unpublished document submitted to the World Health Organization.

Of the two unpublished manuscripts, one is on medical and health conditions in India and the other has some rather pithy remarks on social medicine in medical education. In this latter paper he attempts to summarize a lifetime of experience in the field of medical education and the importance of having a course in the sociology and economics of medicine as part of the four-year medical school program.

Sigerist philosophically was probably a humanist. Politically he was a socialist who considered the sociology of medicine to mean the social aspects of medical care in different nations of the world.

Dr. Roemer should be commended for his fine work in editing the text. However, one finds the book rather repetitious, and in some cases, there are generalizations without empiric evidence. This is a problem in many anthologies and is certainly not restricted to this one edited by Dr. Roemer.

Those administrators that have not taken the opportunity to read any of Dr. Sigerist's work might find this anthology worthwhile reading. The essay, "The Special Position of the Sick," which is even more effective in the original German, is a favorite of the reviewer. Sigerist explained it as follows: "To be ill means to suffer—to suffer in a twofold sense. To suffer means to be passive. The sick man is cut off from the active life to the extent that he is even unable to procure his own food. He is literally helpless and is assigned to the care of other persons."

Some of Sigerist's writing on the socialization of medicine, group practice, and medical education appeared to be rather radical when first published, but today in some cases. are part of our medical care system. Sigerist was a physician, historian, and teacher who had vision far beyond his own years and had a real understanding for social action within the field of the sociology of medicine. On this basis, this book is recommended reading.—*Thomas P. Weil*, associate consultant John G. Steinle & Associates, Garden City, N. Y.

ENSURING MEDICAL CARE FOR THE AGED, *by Mortimer Spiegelman, F.S.A. Published for the Pension Research Council, Wharton School of Finance and Commerce, University of Pennsylvania, Irwin. March, 1960.*

Most administrators and department heads will find this volume an excellent review of lay and professional literature on the controversial subject of medical care for the aged. The reader will be disappointed if he expects to find possible solutions to the problem other than those that have been already proposed in Congress.

Mr. Spiegelman, who is an associate statistician with the Metropolitan Life Insurance Company, is an excellent student of demographic data that affect the problems of medical care and of health insurance. His book discusses the demographic, social and economic characteristics of the aged, the health status and attitudes of the aged, medical care utilization by the aged, medical care expenditures of the aged, and mechanisms for financing medical care of the aged. The final chapter, which is called "Toward A Goal," is predominantly technical rather than interpretive in nature. The earlier books published for the Wharton School's Pension Research Council seem to have sufficient facts and more discussion than one finds in the Spiegelman work.

The administrator who is on a committee discussing the problems in providing medical care to the aged might find this text a handy reference to have on his book shelf. —*Thomas P. Weil*, associate consultant, John G. Steinle & Associates, Garden City, N. Y.

CHILDBIRTH, THE MODERN GUIDE FOR EXPECTANT MOTHERS, *by Charles Richard Alsop Gilbert, M.D. New York: Hawthorn Books, Inc., 1960. 256 pp. $3.95.*

Based on questions asked by more than 3000 expectant mothers, this illustrated book is an up-to-date compendium of information for mothers-to-be.

The author stresses medical developments in pain-relievers, and devotes many chapters to setting at rest the fears and apprehensions of the primagravida, through a discussion of mental attitudes and how they are achieved. Also included is a d'scussion of the value of such modern technics as "natural childbirth" and the role of hypnosis.

Questions and answers are featured at the end of each chapter. The book also contains a glossary of common medical terms and an index.

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TRADE TOPICS . . .

An outstanding research paper in biochemical technic wins Stephen Harold (l.), hospital laboratory technician from Regina, Saskatchewan, the first Fisher Scientific Award for Achievement in Biochemistry. The award — including scroll and $250 check — is presented by W. W. Lummis, president of Fisher Scientific Ltd., for the Canadian Society of Laboratory Technologists at the society's recent meeting in Montreal.

American Hospital Supply Announces New Posts

The election of Hugh B. Hall to president, American Hospital Supply Corporation (Canada) Ltd., a wholly owned subsidiary of American Hospital Supply Corporation, has recently been announced. Mr. Hall will continue as president of Canadian Laboratory Supplies Limited of Toronto.

His new responsibilities include direction of AHSC's entire Canadian operation, which comprises a twin-pronged hospital-laboratory merchandising program to laboratories and hospitals, similar to the parent company's domestic organization.

In another announcement, the appointment of Robert M. Baker to the newly created position of manager of profit planning was reported. Mr. Baker will coordinate profit planning among AHSC's three major sales divisions and 22 subsidiary companies, working out of Evanston, Ill.

And Robert L. Beecher has been appointed sales manager of the seven-state Chicago region for AHSC's hospital supply division.

Baxter Lab Lists New Positions

Charles F. Bowers has been promoted to sales manager for the southwestern district, Flint-Eaton division of Baxter Laboratories, Inc. He has been with Flint-Eaton for nine years and was formerly a medical service representative.

Richard W. Smith has been promoted to district sales manager for the newly-established southeastern district of the Flint-Eaton division.

And Robert G. Tucker, Ph.D., has joined Baxter as manager of scientific services. He came to Baxter from Smith, Kline & French Laboratories where he was a senior scientist and group leader.

In addition, Baxter has announced the purchase of a 47-acre tract of land near Kingstree, S. C., as a site for a new plant. The facilities will be used to manufacture intravenous solutions, blood equipment, and pharmaceutical specialties.

Manager of the new plant will be Donald G. Madsen, who has

(*Continued on page* 123)

In appreciation of his work in behalf of Hospital Industries Association, Harry DeWitt, retiring president, receives a plaque from Roland Simons of C. R. Bard. Mr. DeWitt is vice-president, American Hospital Supply.

Robinson Bosworth (l.), vice-president, Will Ross, Inc., smilingly accepts congratulations on his election to the presidency of HIA from Robert P. Evans, president of Sterilon Corp.

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Sealed Container
to maintain "ready-to-use" sterility.

Blunt Cannula.
Will not cut into or flake bore of PE tubing.

Economically Priced
as a disposable item—but can be re-sterilized and re-used.

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Clay-Adams

(*Continued from page* 121)

been manager of Baxter's plant in Brussels, Belgium.

Sterilon Opens Canadian Subsidiary

Sterilon Corporation has announced the establishment of a new wholly owned subsidiary, Sterilon of Canada, Ltd., Niagara Falls, Ont.

Initially the subsidiary will produce blood transfusion equipment, but plans are that all Sterilon items for Canadian market and some foreign consumption will be produced in the Niagara Falls plant.

Harry D. Taylor has been named sales manager of the Canadian subsidiary, and Gordon J. Taylor is production manager.

In the U.S.A., Sterilon has added two new representatives to its New England territory—James C. Black, Jr., and James J. Dawson.

Scholl Wins Success Award

William M. Scholl, M.D.—is one of the 11 winners of American Success Story awards, presented by the Free Enterprise Awards Association, Inc., to men who rose from humble jobs to become owners and heads of giant industries.

Dr. Scholl is founder and president of The Scholl Manufacturing Co., Inc., Chicago. A farmboy and shoemaker, he worked nights to get his M.D. degree. His designs and patents, says the FEAA, "built a multi-million dollar world-wide foot comfort appliances and remedies empire employing 3000 people in 10 plants, making 1000 varied products from pads to shoes sold through 423 owned or franchised Dr. Scholl Foot Comfort Shops and other stores internationally."

News Notes

Benjamin W. Carey, M.D. — has been elected to a three-year term on the alumni advisory council of Harvard Medical School. Dr. Carey is medical director of American Cyanamid Company's Lederle Laboratories.

James F. Molidor—has been named a product director in the hospital division of Johnson & Johnson.

* * *

Pacific Lift Truck Co. — has been appointed exclusive representative in Southern California for Yale & Towne Manufacturing Co.

* * *

James Johnson — has joined the hospital division of the Seamless Rubber Co.

* * *

Lamson Corp. — recently acquired James A. McKechine Ltd., Toronto, Canada.

* * *

The Schering Corp.—has presented a $37,500 grant to Allergy Foundation of America for production of a public service film on allergy.

* * *

Carolina Absorbent Cotton Company—announces the appointment of two new sales representatives: **Philip L. Nichols** and **C. Pearce Gray.**

* * *

Peter J. Kornett—has been elected a member of the board of directors, Oakite Products, Inc. **J. Justin Basch** has been elected second vice-president of the company, and **William A. Baltzell,** vice-president.

* * *

William A. Mowry — has been named marketing services manager for Shampaine Industries, Inc., of St. Louis.

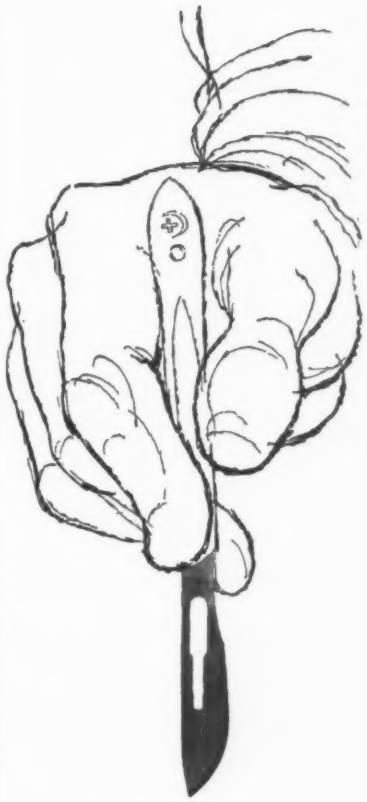
* * *

Robert F. Murray—has been chosen vice-president for operations, A. S. Aloe Division of Brunswick Corp. Mr. Murray will be in charge of all controller and operations functions relating to Aloe and its 18 branch offices.

* * *

Robert T. Besserer—has been assigned to the southeastern sales region for Donald W. Edwards Co., Inc.

(*Continued on next page*)



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surgical blades and handles

For further information see postcard opposite page 126.

The board of directors of **National Aeronautical Corp.** recently acquired **Air-Shields, Inc.** Air-Shields will operate as a wholly owned subsidiary of NARCO.

* * *

Chemetron Corp. – has recently acquired Specific Pharmaceuticals, Inc., as part of Chemetron's products division.

* * *

The Wilmot Castle Co. – will be responsible for sales and distribution of the Bendix line of sonic energy cleaning systems for hospital application.

* * *

Daniel P. Brennan – has been appointed technical service representative in midtown New York City by Oakite Products, Inc. He replaces **Edmund Malone,** who has been transferred to New Jersey.

* * *

The American City Bureau, professional fund raising organization – has established an eastern regional office in New York City. W. D. Curry, vice-president and a director of the bureau, will head the eastern region.

* * *

Crown Surgical Supply, Pasadena, Calif., is now a part of the **Edward Weck & Company.** Crown will continue its present business under the management of Kenneth Schaal and Hal Brand. In addition, the Crown sales staff will sell Weck instruments and specialties, with emphasis on products and systems for central supply.

Mr. Schaal

Mr. Brand

* * *

Gudebrod Bros. Silk Co., Inc., this year is celebrating its 90th anniversary.

* * *

James W. Castleberry – has been named sales manager, Johnson & Johnson's central hospital division, St. Louis, Mo. He is in charge of sales in nine midwestern states. In addition, **James H. Murray** has been appointed a product director for J. & J.'s hospital division.

* * *

Melvin W. Kerner – is new divisional sales manager for Schering Corp.

* * *

John F. Quinn –has joined the Clay-Adams sales staff as district representative in upstate New York and eastern Pennsylvania. He has considerable practical laboratory experience and has previously been engaged in sales work.

* * *

C. Paul Hegarty, Ph.D.–has been appointed manager of the virology section, research division of Wyeth Laboratories.

Mr. Hughes

John F. Hughes – has been named sales specialist for Curity maternity products, The Kendall Company, Bauer & Black. He will travel throughout the country detailing and instructing hospitals on use of the maternity products. Formerly he was a hospital representative for Bauer & Black, and will be succeeded in that position by **Robert Jones.**

* * *

Edward R. Luter–has joined Abbott Laboratories' export companies as vice-president and treasurer. He previously was manager of foreign finance and taxation for Sears, Roebuck & Company.

* * *

James P. Dodd–has been appointed director of sales for the J. B. Roerig and Company division of Chas. Pfizer & Co., Inc.

* * *

Lumex, Inc.–has moved to a new factory and executive offices in Bellmore, N. Y.

* * *

Felix S. Cecot–has been appointed manager of contract sales, surgical products division of American Cyanamid Company. Mr. Cecot is a 1959 divisional winner of Cyanamid's prize for top salesmen.

* * *

R. Lincoln Graydon – has been appointed contract sales manager for Furniture Dynamics, Inc., a division of Hoover Ball and Bearing Co.

* * *

Kemper-Prager Sales Agency, Atlanta – has been named to handle sales of Selectronair, new air purifying instrument, in Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Tennessee, Mississippi, Kentucky, Texas and Louisiana.

* * *

Norman W. Achen – has been appointed assistant to the president, Hyland Laboratories, a subsidiary of Baxter Laboratories, Inc.

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407. Betadine aerosol spray
408. Shoe white
409. Surgent
410. Disposable needle
411. Emergency splint
412. Test tube rack
413. Wall-ceiling cleaner
414. Safetrode
415. Single-dose vial
416. Disposable douche
417. Emergency cart
418. Umbilical cord tier
419. Glass joint
420. Silv-O-Tainer
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422. Stomach irrigation tube
423. Incontinent pad
424. Pak-O-Meter
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427. Hemoccult
428. Aeropedic mattress pad
429. Radioactivity-measuring device
430. Space saver
431. Leg traction unit
432. Disposable plastic cup
433. Ambulance
434. Bed board
435. Disposable syringe-needle

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443. Anatomy chart
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445. Steam cooking
446. Parenteral feeding
447. Anticoagulants

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HOSPITAL Topics

30 West Washington Street
Chicago 2, Ill.

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B-D

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flat trim wrist and naturally curved fingers

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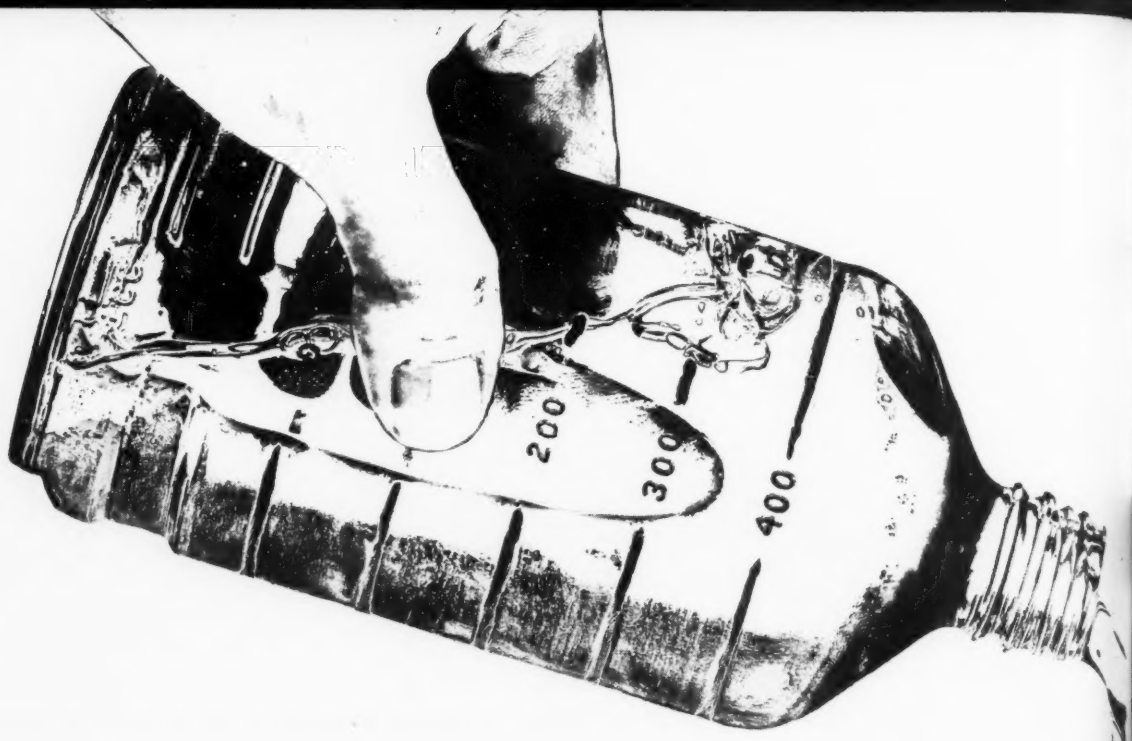

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